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SHELTERING AMERICA'S AGED: OPTIONS FOR HOUSING AND SERVICES

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CONTENTS

Page

Opening statement by Senator John Heinz, chairman 1

CHRONOLOGICAL LIST OF WITNESSES

Flynn, Raymond L., mayor, Boston, MA 3
Anthony, Amy S., Boston, MA, secretary, Executive Office of Communities and Development, Commonwealth of Massachusetts 9
Rowland, Richard H., Ph.D., Boston, MA, secretary, Department of Elder Affairs, Commonwealth of Massachusetts 18
Abrams, Philip, Washington, DC, Under Secretary, U.S. Department of Housing and Urban Affairs 26
Feingold, Ellen, executive vice president, Jewish Community Housing for the Elderly, Brighton, MA 42
Struyk, Raymond J., Ph.D., senior research associate, the Urban Institute, Washington, DC 52
Shea-Roger, Pamela, partner, OKM Associates, Inc., Boston, MA 88
Firman, James P., Ed.D., senior program officer, Robert Wood Johnson Foundation, Princeton NJ 94
Chellis, Robert D., president, National Lifecare Corp., Chestnut Hill, MA 97

APPENDIXES

Appendix 1. Statement of Patricia A. Riley, Augusta, ME, director, Bureau of Maine's Elderly, Department of Human Services 111
Appendix 2. Statements submitted by the hearing audience:
Przybylaka, B., Boston, MA 114
Suitor, Carol Jean, Newton, MA 114
Swander, Susan, Boston, MA 114

SHELTERING AMERICA'S AGED: OPTIONS FOR HOUSING AND SERVICES

MONDAY, APRIL 23, 1984

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Boston, MA.

The committee met, pursuant to notice, at 1:50 p.m, in Faneuil Hall, Boston, MA. Hon. John Heinz, chairman, presiding.

Present: Senator Heinz.

Also present: John Rother, staff director and chief counsel; Stephen Somers and Ann Gillespie, professional staff members; and Isabelle Claxton, communications director.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Chairman HEINZ. Ladies and gentlemen, good afternoon and welcome to today's hearing on sheltering America's aged. I am Senator John Heinz, chairman of the U.S. Senate Special Committee on Aging.

Earlier today, Mayor Ray Flynn and I had the opportunity to visit two elderly housing project sites, and I saw firsthand, thanks to the mayor and to members of his administration, the problems as well as the opportunities in providing appropriate shelter, especially for the low-income elderly. We saw one particularly promising option for meeting the housing and services needs of our senior citizens: congregate housing.

Sooner or later each of us is likely to face the difficult questions that we are here today to explore. A grandparent, a parent, or even a spouse may already have asked us to help choose the shelter options most appropriate to his or her needs. More and more often in the years ahead, Americans will ask themselves the question before us today: How can we minimize the exorbitant human and financial costs of unnecessary institutionalization and at the same time insure for our elders the independence, the quality of life, and the sense of security we all want when we reach an older age of, say, 75.

That was not a question that was before our ancestors 200 years ago when that small band of patriots here took the lead in the struggle for independence, and dumped all that tea into Boston harbor. The average life expectancy at birth for colonial Americans was 35 years, less than half of what it is today. And when an old person in those days became infirm, an extended family was there much more often than not to support them. Long-term care was not in the lexicon of that day and age; 200 years later, based on the

experience I had today, Bostonians are once again taking the lead in striving for independence, this time for older Americans.

The Special Committee on Aging has come to Boston for this hearing because no where else in the country today can one find a comparable range of ideas and experience regarding elder housing and services options.

But, even in Boston, as we saw with Mayor Flynn this morning at the Annapolis housing project, many low-income older persons do not have all the choices that we would ideally like them to have. Some of them may live in fear of inadequate security, in fear of crime, of ill health, of impoverishment in housing units not designed for best sheltering them as they become frail. They live in fear of the demoralizing choice between, at best, continuing to live independently with minimal supervision and sometimes without even minimal services or security, and they live in fear, of entering an institution which costs both them and us dearly in many ways.

Fully 40 percent of the elderly in public housing nationwide are over 75 years of age. Now, not everybody over age 75 is frail, or is in need of services, or is unable to function independently and quite successfully. Nevertheless, we have encountered a phenomenon that I call "aging in place". That is particularly true of our federally assisted housing projects, which have been in existence for 20 or 25 years. As a result, many of those elderly housing projects are in danger of becoming nursing homes without services.

Two years ago today, on April 23, 1982, I chaired an Aging Committee hearing on the impact of the administration's housing proposals on older Americans. Since then, Congress and the administration have essentially maintained the status quo in Federal housing assistance for the elderly. New solutions, new policies, new ideas have largely been placed on hold as we have attempted to do a better job of managing our existing housing. But as the characteristics of our elderly population and our society continue to change, we must now make a serious examination of the broader shelter needs of America's aged, and of policy options for addressing them.

When Mayor Flynn and I were at the Annapolis project earlier today, we had a press conference. At that conference I briefly discussed my intention to introduce legislation amending the Older Americans Act when it comes to the floor in May or June of this year. These housing amendments, which Senator Dodd, who is a member of the Aging Committee, will cosponsor, will increase the capacity of the Nation's 650 area agencies on aging, the AAA's, and the public housing officials to assist the frail elderly in finding suitable shelter and services. Second, the legislation calls for an analysis of policy options for promoting independent living among the frail elderly. Third, the legislation requires the Commissioner of Aging to test and evaluate nonsubsidized options for meeting the shelter needs of moderate-income retirees. Next year, when Congress reauthorizes the major Federal housing assistance programs, I hope that we will also consider additional ways of enhancing the current law's responsiveness to the housing and services needs of the elderly, especially the low-income frail elderly.

It is my hope on behalf of the membership of the Committee on Aging, that this hearing will take the first major step in raising

our national consciousness—in recognizing the aging in place phenomenon, in recognizing the growing danger of our public housing projects becoming nursing homes without services, and in recognizing the urgency of answering the question of how we can insure for all older Americans that same independence and quality of life that we all want for our parents, our grandparents, and ultimately ourselves.

So I look forward today to hearing from our witnesses as to what we can and should do now and in the future to responsively meet the shelter needs of America's aged. It is, therefore, a particular pleasure to have as the first witness the mayor of the city of Boston, Ray Flynn. As I went around Boston today with Mayor Flynn, I got the impression there wasn't a single person in the city not only who didn't know him, but also whom he didn't know.

For those of us who spend so much time out of our districts or States down in Washington it was humbling, Ray, to see how closely in touch you are with the heart beat of your community.

Before I call upon you for your testimony, I just want to thank you for all the arrangements that you and your staff made for the committee, for myself, for Phil Abrams from HUD, and for the staff of the Special Committee on Aging. I want to thank you for your hospitality, and I want to thank you and your staff for giving us some very good insights into the kinds of problems and the kinds of opportunity you are seizing in Boston to make this a truly and ultimately an outstanding example of what can be done to house senior citizens.

We are all cognizant of the fact that a few years ago the housing authority in the city of Boston was placed into receivership. It is also equally, I think, worth noting the tremendous strides that are being made. So, I thank you for making our visit here worthwhile, and I say so on behalf of myself and all the other members of the Senate Aging Committee.

Also on our first panel is Amy Anthony, Massachusetts Secretary of the Executive Office of Communities and Development; Richard Rowland, Massachusetts Secretary of the Executive Office of Elderly Affairs; and, of course, Phil Abrams, Under Secretary of the Department of Housing and Urban Development.

Mayor Flynn, we are pleased to have you as our first witness.

STATEMENT OF RAYMOND L. FLYNN, MAYOR, BOSTON, MA

Mayor FLYNN. Thank you, Senator. I have a prepared statement I would like to submit for the record, but I will make my oral remarks brief.

Let me first of all thank you for coming to the city of Boston, not only to hold this hearing, but also to give people the opportunity to talk about their concerns in the area of housing and supportive services for the elderly. This type of approach that you're initiating, that is, getting out into the various cities and States to generate support for this necessary legislation is a significant way to be effective and develop consensus for passage of this legislation.

I think your legislation is important and I was impressed that Senator Heinz and Senator Dodd—one Democrat and one Republican—are trying to get this bipartisan support for expanding the

Older Americans Act. This approach is certainly an excellent way of going about it, as is bringing that piece of legislation out into the various communities to get constituent support as well. I applaud that kind of effort.

Senator, this morning we had an opportunity in a very short period of time to go out into the neighborhoods of Boston to look at how elderly housing is being implemented. One development provided support services; another development did not.

It indicates both how we can be successful, and what still needs to be done.

We support the legislation that you have introduced because it would provide the training for people to provide needed social services into the various senior citizens developments that require these services.

I mentioned to you and to other people from Washington—particularly Mr. Abrams, the Under Secretary of HUD—that housing is one of the major problems we have in Boston.

There are certain things that the city can do, and there are other things that we cannot do, without the support of the Federal Government and without the support of the State government.

But I think that what is impressive here today is we have the Secretary of Elder Affairs, Richard Rowland; we have the Secretary of Communities and Development, Amy Anthony, along with Mr. Abrams, myself, and Senator Heinz. Together, we can provide a positive kind of approach to deal with some of these problems that we looked at today.

Let me say that there is a real willingness on the part of the people in Boston to come together around the issue of housing. There are many issues that people will disagree on, but housing is an issue that everybody can come together on and feel a part of a process to expand and protect our housing supply.

We will soon be submitting a piece of legislation to the city council which in my opinion will be the most comprehensive housing proposal ever submitted to the city council.

But even with the ingenuity and the creativity that has gone into that housing proposal—expanding the supply of housing, whether it be in the area of homesteading or rehabilitating abandoned housing, or expediting the foreclosure procedure. Of all those myriad ways of dealing with the issue of housing in the city, a key ingredient, of course, is in the area of funding.

We can come up with creative solutions to the process, but in the final analysis, we have a city that has a rental vacancy rate of about 2½ maybe 3½ percent.

This area that we're in right now, Senator, has the lowest commercial vacancy rate of any city in the United States. That's fine, but as we drove by, for example, the Copley Place, which I pointed out to you—it's a $500 million project—which has had a significant impact on the housing contiguous to that particular development. The values of property have increased rather dramatically, and when the values increase, the rents also increase. Many rental units have been converted into condominiums; about 10,000 units of rental housing have been converted into condominiums. In many other rental units, the rents have increased rather dramatically.

So it's put a major burden on low- and moderate-income residents, particularly the elderly and people on fixed incomes. The type of income that these people receive has not been in fact commensurate with the amounts being charged for rents or for housing in our city.

So it's so important, I think, that while we look at Boston as a city that is undergoing significant development in the central area of the city, our downtown area, that by the same token, the neighborhoods of the city have been left behind.

We have to come up with creative solutions and we have to expand the supply of housing into those areas. Along with expanding the supply of affordable housing, also comes the need for providing support services for those particular developments with a frail elderly population.

I am proud to say that the administration is working very cooperatively with the Boston Housing Authority. I think Harry Spence, the receiver, has done a superb job, and I think the tenants of the city have done a superb job in making sure that their voice is represented in the State, city, and Federal governments in terms of various programs.

We now have a city government that is willing to provide the leadership in the area of housing for elderly, and what we're looking for is help from the Federal Government and from the State government.

We want to thank you for coming to Boston to give the tenants and the elderly residents of the city of Boston an opportunity to be heard on this issue. I think you'll find that we have a city and Commonwealth that is really concerned with working with you and working with the U.S. Congress in coming up with ways in which we can provide better services—whether it be in the area of nutrition or social services for our residents, particularly those residents of our city and State who are elderly and frail.

So, Senator, thank you for coming to Boston and I hope that you will pass on this information as to how the people of Boston feel in the area of housing. We know that your record indicates that you're a person who is going to provide leadership in the Congress and the Senate. Therefore, we expect to be able to cooperate and work with you and Mr. Abrams, who knows the Boston area so well, to make sure that people of this city and this State are given the proper attention that they so desperately deserve.

Chairman HEINZ. Mr. Mayor, thank you very much. Your entire prepared statement will be placed in the record at this point.

[The prepared statement of Mayor Flynn follows:]

PREPARED STATEMENT OF MAYOR RAYMOND L. FLYNN

I want to thank Senators John Heinz and Christopher Dodd for giving me this opportunity to talk about the creative and innovative approaches which we in Boston are doing to provide a range of housing and service options for our senior citizens.

This morning, we had an opportunity to visit two senior housing site—one a congregate housing site with social services and one elderly housing site without services on the premises. Viewing these projects emphasized to us that decent housing and social services for our elder population can be provided—when adequate resources and creative solutions are made available.

I also want to thank Secretary Amy Anthony and Under Secretary Phillip Abrams for their presence at this conference. As most of you know, many of the

programs that the city can institute or support for elderly housing are funded through either the State or the Federal Government, so I'm sure we'll all be interested in their remarks.

In Boston, we have a wide range of elderly housing needs which must be addressed by a comparably wide range of local initiative. We have elderly renters who have lived with the fear of exorbitant rent increases and displacement as well as elderly homeowners on fixed incomes who have had difficulty in meeting the rising costs of fuel and maintenance. Moreover, senior renters and homeowners alike are particularly susceptable to crime and those who would prey on their frailties.

A substantial portion of our elderly population falls within the neediest segment of our society. There are 95,262 Boston residents over the age of 60; of them, 12 percent fall below the poverty level. While 12 percent may not seem like a large number, we are talking about over 11,000 older people in our city whose incomes fall below the figure of $4,389 a year. Further, there are about 7,500 seniors who are paying over 50 percent of their income for rent.

Very soon, in response to the housing crisis in out city, I will introduce a comprehensive housing package which will provide protection for Boston's renters—young and old alike—while assuring landlords a reasonable rate or return on their investments. This legislation will protect our senior citizens from evictions as a result of condominium conversions, and it will protect them from exhorbitant rent increases. We owe our senior citizens a better fate than to be turned out of their homes at age 70, 80, or even 90, and this legislation will work to alleviate this situation.

We also are supporting programs which help elderly homeowners maintain their homes. Two nonprofit organizations which have received city funding, the ecumenical Social Action Committee of Jamaica Plain and United South End Settlements of the South End, run a mix of home repair assistance and counseling programs which have enabled seniors to remain in their homes. Presently, these two groups are participating in a "home equity conversion" program coordinated by Action for Boston Community Development and funded in part through the city's elderly commission. It is my hope that this demonstration will lead to further initiatives that will address the "house rich, cash poor" situation faced by many elderly homeowners around the country. At the same time, we must recognize that this is simply one option for certain homeowners and not a substitute for the essential service programs which our society must provide for its senior citizens.

We must also rehabilitate housing for senior citizens. I am fully committed to an agenda which restores the Boston housing authority to city accountability and continues the work of rehabilitating numbers of units—elderly and family alike—to habitable condition. I am also strongly supportive of the work that the nonprofit housing corporations in Boston have done to develop decent and affordable senior housing and look forward to supporting proposals which address this need.

Together with the provision of adequate housing for seniors, we must also work to assure that there are a range of supportive services available for our elderly. This is particularly true in our BHA developments where over 70 percent of the elderly population is over 70 years of age. We must look to promote programs that preserve the independence of our seniors for as long as possible while also promoting the idea of interdependence through home sharing and congregate housing options. In Boston, the city has used community development block grants to assist a nonprofit organization, Back Bay Aging Concerns, to develop its second shared living residence. These programs are an important bridge between living alone independently and the often costly and sometimes unnecessary option of nursing home care.

In addition to serving the housing needs of our seniors, we must also provide adequate health care services, particularly to those who are homebound or living in nursing homes. In February, we began a managed care program for frail elderly which will develop a network of personalized care for our high risk frail elderly population. The program is based on a successful model developed by the Urban Medical Group of Jamaica Plain which has resulted in reducing frail elderly hospital admissions by 25 percent and shortening hospital stays by 40 percent.

The initial funding for this effort has been provided through the Blue Cross/Massachusetts Hospital Association Fund for Cooperative Innovation. We welcome this grant and look forward to developing other public/private partnerships to meet the housing and health care needs of our senior citizens.

We must also insure that our senior citizens are able to live safely in their communities, particularly residents of public housing. To that purpose, the city has allocated block grant funds to provide additional security at BHA developments. Additionally, although we are facing severe budget constraints in our city, I am proposing an increase in the police department budget which will put more police on the streets, throughout our neighborhoods.

The real challenge for us over the next decade is to provide our growing population of senior citizens with the shelter and the services they deserve. To do this, we must forge the necessary partnerships, including all levels of government, the private and charitable sectors, neighborhood groups and seniors themselves. Senator Heinz has proposed legislation today that will spur new and creative approaches in senior housing and social service delivery. I strongly support this legislation and will ask the support of our Senators and Congressmen to make these proposals a reality.

I believe that decent and affordable shelter, as well as access to necessary social services, is an essential right for all people—especially our senior citizenry. We must provide this dignity and respect through our strong and contrived commitment to affordable senior housing and necessary social services.

Chairman HEINZ. Mr. Mayor, I want to say that you are illustrative to my mind of a new breed of mayor who really does understand and care about housing. It hasn't always been that way. You and Mayor Wilson Goode of Philadelphia, who was like you elected last November, have both come into office determined and well equipped. You as a State legislator before you were councilman, represented, as I understand it, more public housing units in your legislative district than any other legislator in the United States.

You come uniquely well equipped to understand and therefore care about housing. It is an area that does not receive all the attention that is lavished on such issues as the Federal budget and the environment, and yet what is more important than the environment in which one spends the largest single part of one's time.

I would only add that Senator Dodd would, I think, second what I just said. Senator Dodd campaigned for Mayor Flynn, and as Mayor Flynn pointed out to me when they were in the Italian part of Boston, Senator Dodd kept talking in Italian, which was wonderful from a campaign point of view, but according to Mayor Flynn a little frustrating because he never knew what Chris Dodd was saying.

You mentioned in your statement the housing plan that you are going to submit. What in your opinion is the most important contribution that the Federal Government can make to support what you are going to ask the city and/or the State to do in your housing plan?

Mayor FLYNN. Senator, I think that the area that we're concerned about here in Boston is in the area of elderly housing and family housing. But let's talk a little bit about elderly housing for a minute.

I wish Harry were here, but we have a waiting list for housing in Boston. It's about 6,000 people on the waiting list. It's about 2½ years before people can get into elderly developments.

I'd say, if there were somebody here from my office of constituent services, they would probably tell you that the calls that they receive continually are in the area of housing. There is not a public meeting, or there is not a meeting that I can go to anywhere, in any neighborhood of the city at which I don't get many requests in the area of housing.

One of the reasons why the Boston housing authority was taken over by the courts was because of mismanagement and neglect. I think significant progress has, in fact, been made in that direction and I think that Mr. Abrams could testify to that fact, that that's one of the positive things that is coming out of the city; the Housing Authority is beginning to work well.

And I expect that that will be a department of the city within a year, and we hope to have that same kind of progress, to show that same kind of progress.

Last year over 60 percent of all our property in the city of Boston was tax exempt, 60 percent, a phenomenal figure, the largest of any city in the United States.

And the only way that we provide services to the people in the city is through a property tax, and we have the proposition 2½ similar to proposition 13 in California, which in fact limits the tax levy for the Commonwealth of Massachusetts and for the city of Boston.

So it really means that we're going to have to come up with a couple of things: We're going to have to have creative and effective programs, and No. 2, finances and help from the Federal Government.

But as I say to Mr. Abrams, and to yourself, Senator, you send us the programs and we will honestly administer those programs in a very effective way. You won't have to worry about it being top-heavy with administration; you won't be embarrassed to see that the money has not been prudently spent and money that we get will go to services for these people out here, and other people in the neighborhoods of the city.

Chairman HEINZ. Mr. Mayor, thank you. It is a pleasure for us to be here in Boston. You can stay if you wish, or if you have other appointments, and I know sometimes mayors get a little busy, please feel free to leave.

Mayor FLYNN. Thank you.

[Subsequent to the hearing, Mayor Flynn submitted the following information:]

MAYOR RAYMOND L. FLYNN'S RESPONSE TO SENATOR HEINZ QUESTION ON THE FEDERAL ROLE IN ELDERLY HOUSING

The Federal Government must resume its lead role in supporting the development of affordable housing for senior citizens and families alike. We must once again consider the provisions of decent and affordable housing as a priority on our national agenda.

Boston needs a continued Federal commitment in the area of public housing that will help us modernize our older units. We need a commitment by Washington, to provide the coordinated social services needed for our frail seniors in public housing developments. Also, as a city where 70 percent of our population are renters—most of whom are of low and moderate incomes, we need housing subsidies with adequate fair market rents to allow for access to our increasingly expensive housing market.

In Massachusetts, we are fortunate to have a creative State government that has responded to a number of our housing needs with innovative programs such as the congregate housing units we toured this morning. This creativity at the State level should not be used by the Federal Government as an excuse to walk away from its own responsibilities. Rather, we need the Federal Government to look at what works at the State and local levels and provide the incentives for more successful housing initiatives to meet our great needs.

Chairman HEINZ. Our next witness is Amy Anthony, the secretary of the Executive Office of Communities and Development for the State of Massachusetts.

Ms. Anthony, please proceed.

STATEMENT OF AMY S. ANTHONY, BOSTON, MA, SECRETARY, EXECUTIVE OFFICE OF COMMUNITIES AND DEVELOPMENT, COMMONWEALTH OF MASSACHUSETTS

Ms. ANTHONY. Mr. Chairman, my name is Amy Anthony, and I am secretary of the executive office of communities and development. It's good to be here today. I can say that in my 15 months in this position, even as intractable and difficult as the problems of housing are, it has been a joy to work for a Governor who takes housing as seriously as he does. You certainly echoed my thought by your comments about the mayor, who has made housing a very visible and important part of his agenda, which I certainly want to give him great credit for.

We look forward to working together to address many of those problems.

I am pleased to testify today about a topic of great importance to the State and the Nation as a whole, elderly housing. Among its many duties, EOCD administers this Commonwealth's public housing programs, perhaps the most extensive, comprehensive, and successful programs in the United States.

We have committed more State dollars to housing than any other State; in fact, we have recently expanded our efforts with the enactment last December of the Comprehensive Housing Act of 1983, which provided $196 million for new construction of elderly, family and handicapped housing and revitalization of the older, State-aided housing stock.

Responding to elderly need has been critical to our overall efforts to provide safe, decent and affordable housing. This priority has more recently emphasized the congregate elderly program that concerns us at this hearing.

Of the approximately 100,000 subsidized elderly housing units in Massachusetts, the State has built 31,000 units through $700 million in construction grants to local housing authorities across the State.

We currently have 521 developments in 190 of the 351 cities and towns of Massachusetts, developed and managed by local housing authorities, with the strong support of local communities.

Our congregate elderly program began as a demonstration program in 1976. Since that time, 225 congregate units have been built within 18 developments. I might add that we are now in the process of expanding that program through the proposal process currently underway to disburse the $196 million in new housing funding. More than $66 million of this funding will be used for elderly housing. The legislature, with our concurrence, placed a strong emphasis on congregate, urging maximum use of this approach.

Local interest is very strong; 64 cities and towns have submitted proposals for 919 congregate units under the first round of this funding. This represents funding requests of nearly $35 million for congregate housing construction alone, substantially more than we could possibly fund, given our $33.3 million limit for all elderly housing under this first round.

But I think the response indicates the popularity, success, and need for the program on a statewide basis. Let me briefly touch

upon whom our congregate program operates for, what it looks like, how it operates.

This housing is for low income, frail elderly. By frail, I mean anyone with an impairment: A strong person in a wheelchair, a blind person, someone who is able-bodied but forgetful, someone who is lonely. It is someone who has a functional impairment and/or is socially isolated, who is not capable or does not wish to live a totally independent life, but a person who is not a candidate for the constant supervision and intensive health care of an institution.

The congregate elderly development is an alternative to institutionalization where the residents provide mutual support, companionship, and the necessary elements that mean an independent lifestyle. Through shared physical space, the residents share the activities of daily living, and where necessary, help each other to live full and meaningful lives.

There is no supervision of the residents. Congregate housing is clearly a housing option. But, through the extensive network of home care service agencies and providers, and under a memorandum of understanding between my agency and the Department of Elder Affairs, more recently expanded to include the Massachusetts Department of Public Welfare, congregate housing residents will receive priority status for home care services. The Department of Elder Affairs has also agreed to fund a congregate housing service coordination for each development which would include a needs assessment and actual service coordination element for each development.

Secretary Rowland of DEA will discuss services in greater detail, but I do believe that programmatic coordination at both the State and local levels is a key to success in congregate housing.

We've had extraordinary cooperation at the State level in Massachusetts and our demonstration program indicates that we've had equally good cooperation at the local level.

Indeed, proper planning, coordination and service delivery is the cornerstone in the foundation of the congregate program.

Physically, a congregate development is a multi-bedroom apartment or house where each resident has his or her own bedroom, and in some cases, a private bath and kitchenette. Residents share other living areas, often including a large eat-in kitchen, or kitchen and dining room, living room and other spaces. These developments have ranged from 3 to 20 bedrooms. In designing these developments we have been careful not to fix the divisions between public share space and private space. We have found that flexibility makes each congregate unique, and appropriately individualized.

The amount of share space is determined by local agencies, based on their assessment of the needs of their particular congregate population, and we have found that design elements as simple as a Dutch door on bedrooms can allow residents to control and change the boundaries between public and private space.

There is no single model for congregate units or developments. They may involve new construction or adaptive reuse of an older building. EOCD has learned a great deal about design and the needs of this population over the past 8 years, and we strongly believe that good, flexible design is an all important element.

Therefore, our architects work closely with the locally designated architects who actually design the units, and with the service providers to determine what the necessities of any given project should be.

The results have been enlightening. For instance, our traditional one bedroom elderly units cost between $30,000 and $40,000 per unit, sometimes as high as $50,000, but clearly less costly than the $70,000 and more which HUD units can cost.

EOCD's congregate units, however, have cost between $15,000 and $30,000 per bedroom, an extensive savings. The design modifications which encourage sharing and facilitate mutual help also lower construction costs, and in turn have reduced service costs.

But, I must add, never at the expense of giving residents less housing for the money. Rather, residents are getting housing more suited to their particular needs.

We believe that the Massachusetts experience can serve as a cost effective national model for Federal programs. We further believe that through such a program, health care costs can be contained, and a more productive, more independent lifestyle can be promoted and maintained for the frail elderly.

The congregate housing concept is an alternative that goes beyond mere efficiency. It is a housing option that can greatly enhance and improve the quality of life for a great many old people in this country.

We urge this panel to consider our experience and to work with Federal housing agencies, health funding, and home care agencies to coordinate and make funding available at the Federal level. I believe such an approach has enormous promise for the future of elderly housing in the United States.

Thank you, Mr. Chairman.

Chairman HEINZ. Secretary Anthony, thank you for an excellent description of the congregate housing program and its parameters. Your complete prepared statement will be placed in the record as this point.

[The prepared statement of Ms. Anthony follows:]

PREPARED STATEMENT OF AMY S. ANTHONY

I. INTRODUCTION

I am here today to describe Massachusetts' congregate housing program. Congregate housing is housing for low-income "frail" elderly in which design modifications and the availability of home care services address the shelter, social, and service needs of each resident. The word "frail" evokes the image of the very old, fragile person who walks slowly and deliberately with a walker. By frail, I mean anyone with an impairment—a strong person in a wheelchair; someone who is blind; someone who is able bodied but forgetful; someone who is lonely. Separately, each one of these people is frail and precluded from living alone. Together, it is their strengths that are emphasized and their independence made possible. The person in the wheelchair can shop; the blind person is the memory for the forgetful; the forgetful can cook.

Technically, frail elderly is used to describe an elder who has a functional impairment and/or is socially isolated and is not capable or does not wish to live a totally independent life, but is not a candidate for the constant supervision and intensive health care of an institution. Congregate is not a nursing home; nor is it a medical care facility. There is no supervision of the residents. It is a housing option.

My agency, the Executive Office of Communities and Development, is a housing agency. We provide grants and technical assistance to local housing authorities to construct housing for the elderly, families, and the handicapped. As part of the el-

derly housing program, we have funded the congregate housing program. The Department of Elder Affairs funds home care services through local home care corporations. Working together at the state level and the local level, these two agencies provide the components of the congregate housing program—shelter and services.

The Commonwealth believes that the State-funded congregate housing program can serve as a cost-effective model for Federal agencies. The program shows the benefit of flexible design standards and the benefit of integrating home care services and shelter. The congregate program demonstrates that a partnership between the housing agency and the service agencies can improve the quality of life for the elderly. This partnership can be replicated at the Federal level.

As the cost of providing housing and services for the elderly grows, Massachusetts will be able for a while to provide State dollars to construct congregate housing and elderly housing. Massachusetts will be able to fund home care services to the elderly in State-funded congregate and even improve home care to State-funded conventional elderly units. The Commonwealth will not be able to afford to expand its programs to cover the elderly in federally funded units—the major elderly program in Massachusetts. It is imperative to focus Federal dollars to those elderly.

II. THE STATE-FUNDED ELDERLY HOUSING PROGRAM

I would like first to give you a few facts about Massachusetts. The State population is almost 6 million. There are 725,000 people over 65 (12 percent). EOCD's housing needs study shows that 110,000 elderly need housing assistance in addition to those who are already in subsidized housing.

In Massachusetts, there are approximately 100,000 subsidized units of housing for the elderly. Of these 100,000 units, the Commonwealth has funded the construction of 31,000 units by providing $700 million in construction grants to local housing authorities. Most of the other units are funded with Federal dollars through HUD public housing, 202, section 8, and the Farmers Home Administration. Massachusetts continues to support its commitment to meet the housing needs of the elderly while the Federal Government has been walking away from its housing construction programs, Massachusetts has again renewed its commitment with a $66.6 million bonding authorization—part of a $196 million bonding authorization legislated in December 1983—which will fund the construction of approximately 1,500 additional units of elderly housing. These are all State dollars. A significant number of congregate units will be funded this year.

The Massachusetts elderly housing program—one of the few State-funded housing programs in the country—comprises 31,000 units located in 521 developments in 190 of the 351 cities and towns. Produced and managed by local housing authorities, the developments are created by vote of local communities. Most of the units built by the State for the elderly have been 1-bedroom apartments. Started as a demonstration program in 1976, we are now prepared to expand the congregate approach which currently comprises 225 units in 18 developments.

III. THE STATE-FUNDED ELDER SERVICE PROGRAM

I would also like to touch briefly on elder services, althought Secretary Rowland will discuss these services in detail. Parallel to the State's statewide elderly housing program is the State's extensive network of agencies which deliver home care services. Virtually all of the State is covered by home care delivery agencies. Home care services are crucial to the success of the congregate program—in particular, home makers, meals, health care, and transportation (see table A).

IV. COMBINING HOUSING AND SERVICES

The congregate housing program was designed from the beginning to serve both the shelter and service needs of the "frail" elderly. The mechanism to ensure the coordination between the shelter provider and the service providers is a memorandum of understanding (MOU) between EOCD and DEA (more recently expanded to include the Massachusetts Department of Public Welfare). In the MOU, EOCD agrees to build and to provide funds to operate congregate housing. DEA agrees that the residents of State-funded congregate housing will receive priority status for receiving home care services, and agrees to fund a congregate housing service coordination for each congregate development. The MOU also establishes a task force of the state agencies to coordinate the program at the State level.

The State MOU requires that, at the local level for each congregate development, the DEA-funded housing service coordinator establish a multidisciplinary assessment team (MAT). The MAT includes the coordinator, the local housing authority,

and representatives from each major service provider. Through the MAT, the coordination of shelter and service needs of each resident is ensured at the level of the individual development. The coordination is also formalized in an MOU signed by the service participants and the housing authority.

V. THE CONGREGATE HOUSING DESIGN

A congregate unit is a multibedroom apartment or house. The only fixed element is that each resident has his/her own bedroom. In addition, each resident may have a private bath, and kitchenette. Residents share a large eat-in kitchen, or kitchen and dining room, living room, and sometimes other living areas. Congregate developments have ranged from 3 to 20 bedrooms.

The division between public space which the residents share and private space which is their own is not fixed. It is that very flexibility that makes each congregate unique and appropriate to its residents. Each resident is left with his/her choice of being private or socializing. One simple design component is the use of a dutch door on the bedrooms of one congregate. When the upper part is open, visitor are welcome. When it is closed, the resident wants to be alone.

The amount of sharing is determined by the local agencies when they assess who their tenants will be. If the future residents will be moving from nursing homes, a private bedroom and the availability of a living room are luxuries. Shared baths are taken for granted and do not represent a loss of privacy. If future residents are moving from their own apartments and not used to sharing, more private space may be provided to ease the transition. Then care in the design and location of the shared spaces becomes particularly important to ensure that the resident is encouraged to leave his/her own room.

There is no single prototype model for congregate units. Designs have varied with the population served and whether the development was new construction or adaptive reuse of an old building. As examples: two six-person congregate apartments are located in a rehabilitated, three-story high school that also contains 66 traditional elderly units. Each congregate apartment has two living rooms, a dining room and kitchen. Another old school building contains all congregate units. The 36 residents live on three floors in two seven-bedroom units, two six-bedroom units, and two five-bedroom units. Each unit has its own kitchen, dining room, small lounges, and shared tub/shower rooms. Each bedroom has its own toilet room. In addition, a common living room area is on each floor. As a final example of a school building reuse, there are also the 15 congregate housing residents in a former elementary school. This building contains three five-bedroom congregate apartments each with two full baths and one half-bath, dining room, living room, and kitchen.

Other examples of adaptive reuse include a rehabilitated fraternity house, a renovated sea captain's house to which there was added a considerable amount of new construction, and a converted hospital. Finally, some congregate apartments are located within typical, new construction developments. This often allows the possibility of providing spaces for other activities. Some that have been mixed successfully with congregate housing in the same building include nutrition sites, work-training programs for the elderly, council on aging offices, housing authority office, and elderly drop-in centers. Chart B describes more fully each congregate development to date.

Although congregate settings range widely in design, several general features are common to all and are essential to the congregate living arrangement:

(1) The design creates a shared-living environment. This can include joint use of common rooms as well as sharing responsibility for meal preparation, and daily living activities such as shopping and social activities.

(2) The physical environment facilitates the use of shared spaces. As people age, there is a natural tendency to withdraw from social encounters. The easier the physical environment makes it to have social encounters, the more likely residents are to take advantage of the sharing that congregate housing provides. It is essential that congregate housing residents have natural reasons for coming into the shared spaces—such as by having to pass the living room to go to the kitchen.

(3) Congregate apartments are independent entities.

(4) A network social services must be available for those residents who need such services. This does not mean that there are any "in-house" medical or other support services. There should not be—in fact—as congregate is not a substitute for more intensive care facilities.

(5) Each resident has as a minimum their own bedroom but other spaces may be common to all residents of the congregate. All efforts are made to create a home

atmosphere and encourage both independent and positive interaction with other residents.

VI. HOUSING COSTS

EOCD is currently constructing traditional one bedroom elderly units for $30,000 to $40,000 per unit. The most costly units have cost $50,000 at a time when HUD costs are as much a $70,000 a unit and sometimes more. EOCD is constructing congregate units for $15,000 to $30,000 per bedroom. Much of the saving is from building fewer full kitchens and bathing facilities and by providing fewer but larger living areas. The design modifications which were introduced to encourage sharing and to facilitate helping one another, have, in fact, lowered construction costs. The design, by facilitating mutual help has, in turn, reduced service costs. Some residents have been able to discontinue or reduce the amount of home care services that were necessary in a previous living situation. EOCD does not believe that the congregate residents are getting less housing for the money. They are getting different housing which is more appropriate to their particular needs.

VII. CONCLUSIONS

The logical extension of the State-funded congregate program is to include some of the other 31,000 units of housing for the elderly. EOCD is proposing to modify the design of some units to facilitate the sharing concept and the development of congregate care services through a joint effort of the local housing authority and home care providers, facilitated by a congregate housing service coordinator. EOCD has begun discussions with DEA on this idea and has asked local housing authorities to submit proposals.

Providing an alternative to the one-bedroom apartment or the nursing home for frail elderly who can maintain themselves with a little help is crucial to containing health costs in the United States. Massachusetts believes that its congregate program is an alternative which provides choice. We urge this panel to work with the Federal housing agencies, the health funding, and home care funding agencies to coordinate their programs in the way that is happening in Massachusetts and to make funds available to expand the congregate housing program as Massachusetts knows it, to those projects which are the responsibility of the Federal Government.

TABLE A.—SUPPORT SERVICES FOR CONGREGATE HOUSING

Service	Provider	Funding agency
Meals	Meals on Wheels	Title 3–C (Federal)/DEA/Home Care Corp.
	Nutrition site	Title 3–C (Federal)/DEA/Home Care Corp./Tenant.
	Homemaker	DEA/Home Care Corp.
Housekeeping	Homemaker	DEA/Home Care Corp./tenant.
	Choreworker	DEA/Home Care Corp.
	Housing authority (common space)	EOCD
Shopping/errands/companionship	Homemaker	DEA/Home Care Corp./tenant.
	Companion	DEA/Home Care Corp.
Laundry	Laundry service (very frail only)	DEA/Home Care Corp.
	Homemaker	DEA/Home Care Corp.
Transportation	Community vans	DEA/Council on Aging.
	Taxis/vans	DEA/Home Care Corp.
	Public transportation	Federal/Regional Transit Authority.
	Medical transportation	Medicaid.
Health	Visiting nurse/health aide	Medicare/Medicaid.
	Neighborhood health services	Title 3 (Federal)/DEA.
	Private provider	Medicare/Medicaid.
Personal care	Homemaker/health aide	Medicare/Medicaid/DEA.
Counseling/case management	Congregate service coordinator	DEA.
	Case manager	DEA/Home Care Corp.
	Nurse/health aide	Medicare/Medicaid.
	Local mental health clinic	Medicaid DMH.
Adult day health care	Adult-day health centers	Medicaid.
Adult social day care	Adult-day health centers	DEA.

CHART B.—DESIGN MODELS OF CONGREGATE FACILITIES

Project name	Number of residents and type of construction	Design model	Special features	Congregate construction cost	Service coordinator	Status
Amherst 667–3 (Chestnut Court).	23—Rehabilitation of former fraternity house. 2-stories with basement (elevator).	Mixture of "Hotel" and various-sized apartments: 8-bedroom "Hotel"—each bed with ½ bath, shared lounge, dining room, kitchen. 5-bedroom apartment—2½ baths, shared living room, dining room, and kitchen. 4-bedroom apartment—2 baths, shared living room, dining room, kitchen. 3-bedroom apartment—1½ baths, shared living room, dining room, kitchen. 2-bedroom apartment—1 bath, shared living room, dining room, kitchen. 1-bedroom apartment—1 bath, efficiency.	Adjacent to traditional 667 project, includes solar trombe walls on south, nutrition site built with Town CDBG funds.	$21,700/bed ($34.66/s.f.).	Amhers' Council on Aging.	Occupied since January 1981.
Barnstable 667–3 (Captain Clarence Eldridge House).	20—Rehabilitation of former captain's house (20 percent) with wood frame addition (80 percent) (20 story with elevator).	"Boarding House" Scheme of individual bedrooms with ½ bath and shared tubs. 12 have own kitchenette, 4 share with neighbor. (2) 2-bedroom suites.	3 living rooms/dining rooms, central eat-in kitchen with cook, units circle open litewell with skylight.	$28,524/bed ($57.09/sq. ft.).	Barnstable Housing Authority.	Occupied since March 1981.
Boston 667–5 (Summer Street).	8—2-story wood-frame walkups (104 units).	(2) 4-bedroom apartments in 1 building. Each unit has 2 full baths, kitchen, and dining room. 2d-floor apartment nonfrail elders (no elevator).	Shared-living units are in same building as community space but with separate entrance, project in Southwest Corridor area.	$21,176/bed ($50.30/sq. ft.).	O.K.M. Association.....	Occupied since March 1981.
Cambridge 667–2 (116 Norfolk St.).	41—Rehabilitation of former convent (4 stories, elevator).	"Hotel Scheme". All bedrooms have ½ bath, 17 full baths, 4 kitchenettes/dining rooms shared by 10 people each. 17 bedrooms have small living room each.	Nutrition site, elderly work training program.	Acquired for $19,512/unit.	Housing Services Group....	Occupied since November 1976.

CHART B.—DESIGN MODELS OF CONGREGATE FACILITIES—Continued

Project name	Number of residents and type of construction	Design model	Special features	Congregate construction cost	Service coordinator	Status
Cambridge 667–3B (Putnam School).	9—Rehabilitation of former Putnam School. 4-story, elevator (33 units).	(3) 3-bedroom apartments with own kitchen, 2 full baths, living room.	Section 8 project, CDBG contribution of $200,000, large shared lounge.	$26,640/bed ($39.96/ sq. ft.).	E.C.H.D	Occupancy February 1983.
Chelmsford 667–3 (McFarlin Manor).	4—Rehabilitation of school with 4-story addition (50 units).	4-bedroom apartment on first floor of school sharing kitchen, 2 full baths, dining and lining rooms.	Section 8 project, community space for whole project.	$22,728/bed ($49.41/ sq. ft.).	Elder Service of the Merrimack Valley.	Occupied since September 1982.
Concord 667–2 (Bulkeley Terrace).	36—Rehabilitation of former Peter Bulkeley School (3-story, elevator).	(2) 7-bedroom clusters; (2) 6-bedroom clusters; (2) 5-bedroom clusters; each with own kitchen, dining room, small lounges and ½ baths. Shared tub or shower rooms.	Nutrition site, Housing Authority offices, elderly drop-in center, Council on Aging office, 2 lounge areas.	$27,183/bed ($41.47/ sq. ft.).	Minute Man Home Care Corp.	Occupied since March 1981.
Fitchburg 667–5 (50 Day Street).	9—7-story masonry and brick, elevator building (123 units).	9-bedroom "hotel" on 1st floor of building. Each resident has own full bath. Shared kitchen, living and dining rooms, and lounge.	Housing Authority offices, "hot meal" delivery program.	$14,400/bed ($34.14/ sq. ft.).	Montachusetts Home Care.	Occupied since April 1980.
Ludlow 667–3	3—Rehabilitation of former school	1–3 bedroom unit, living room, kitchen-dining area, 2 baths.	Elderly center included in school rehabilitation.	$29,000/bed ($34.54/ sq. ft.).	Wilbraham Housing Authority.	Occupied since September, 1982.
Peabody 667–6 (Seeglitz School).	12—Rehabilitation of former high school (78 units, 3-story, elevator, basement).	(2) 6-bedroom suites. Every 2 units share a full bath, 2 lounges, dining room, and kitchen in each suite.	Nutrition site, central atrium is community space for whole building, Council on Aging and LHA offices and elderly drop-in center in basement, Section 8 project.	$18,473/bed ($30,72/ sq.ft).	Peabody Council on Aging.	Occupied since April 1980.
Pittsfield 667–3 (Providence Court).	10—Rehabilitation of former St. Luke's Hospital and annex (5 stories, elevator 103 units).	(2) 5-bedroom apartments. 3 full baths, kitchen, dining, and living rooms per apartment.	Community space for entire project, shared lounge for both congregate apartments, fully sprinkled building.	$20,604/bed ($39.51/ sq. ft.).	Berkshire Home Care Corp.	Occupied since March 1981.
Stockbridge 667–1 (Heaton Court).	4—2 and 3-story wood-frame walkups (52 units).	(1) 4-bedroom apartment with living room, dining room, and kitchen, 2 full baths.	Inter-connecting door between unit and community building.	$15,848/unit ($37.04/ sq. ft.).	Berkshire Home Care Corp.	Occupied since 1979.
Tyngsboro 667–1 (Birney Terrace).	4—New construction 2-story wood-frame walkups. (56 units).	4-bedroom apartment on ground floor with 2 full baths, kitchen, dining and living rooms.	Section 8 project, some passive solar, community building for whole project.	$15,381/bed ($51.10/ sq. ft.).	Elder Service of the Merrimack Valley.	Occupied since June 1982.

Wakefield 667–3 (Lincoln Terrace).	15—Rehabilitation of former Lincoln School (25 units total) (2 story and basement with elevator).	3 clusters of 5-bedroom apartments each with 2 full baths and ½ bath, dining room, living room, and kitchen.	Section 8 project, future nutrition site, future Council on Aging.	$19,738/bed ($36.37/sq. ft.).	Eastern Middlesex Mental Health Clinic.	Occupied since February 1982.
Dalton 667–2	4—Rehabilitation of frame house	4-bedroom, 1 living room, dining room, country kitchen, 2 bathrooms (full).	On same site with traditional 30 unit 667 project and 6 unit 705 project..			In court.
Newton 667–2	10—New construction	2 5-bedroom apartments				In planning.
Northhampton 667–3	8—New construction	2 4-bedroom apartments. Each has 1 large kitchen, dining room, 2 toilet rooms, 1 shower room, 1 bathing room.	Part of traditional 667 project, multi-purpose room for community-wide use will be included in project and serve as a nutrition site.			Awaiting court appeal of comprehensive permit.
Wilbraham 67–2	15—Rehabilitation of former school..	15-bedroom congregate house. Each bedroom has its own kitchenette. Shares bath; parlor, dining room, 2 TV rooms, eat-in kitchen.				In construction.

Chairman HEINZ. I will reserve my questions for you until we have heard from your copanelists because those questions will deal with the same subject. So, let me turn to Secretary Rowland at this point, the secretary of the Executive Office of Elder Affairs for the Commonwealth of Massachusetts.

Mr. Secretary, welcome and please proceed.

STATEMENT OF RICHARD H. ROWLAND, PH.D., BOSTON, MA, SECRETARY, DEPARTMENT OF ELDER AFFAIRS, COMMONWEALTH OF MASSACHUSETTS

Mr. ROWLAND. Thank you very much, Mr. Chairman. I want to thank you for coming to Boston today, and I also want to thank you, and I know there are many members of the audience who want to thank you for your brilliant insight and leadership of this Special Committee on Aging in the Senate. You've been a very positive force there and we're very grateful for that.

Massachusetts has made great strides in meeting the housing, health, and social services needs of our elders. Congregate housing has emerged here as an excellent option for people seeking an alternative to living alone, isolated and vulnerable, or entering a nursing home.

Congregate housing offers many seniors a great advantage. It gives them dignity; it gives them support. It helps them maintain their independence.

We have heard many anecdotes about the warmth and sense of contribution that seniors get from congregate living. It offers them a quality of life that must be reflected when government policies are shaped.

Massachusetts will spend $85 million this year for home care services to over 43,000 people. This program gives priority to the residents of congregate housing when they need services. Congregate housing is a very small percentage of our total supply of elderly housing in Massachusetts.

However, there are 245 State funded units, and 16 percent are located in rural areas. There are also 572 private units and 342 units under the HUD section 202 and congregate housing services programs.

So, all in all, Senator, we have over 1,100 units of congregate housing in this State. And I might say that when we talk about congregate housing, I know that some people make a distinction between shared living and congregate housing. When we're talking about congregate housing, it would encompass that concept of shared living and also people that get services, that have their own self-contained apartments.

Looking at other States, it is clear that there is no single definition or model of congregate housing. Connecticut, Maine, Maryland, New York, New Jersey, and Vermont have initiated varying congregate housing programs.

All of these States attempt to integrate shelter and services, but the housing design, level, and method of delivering services varies among the programs.

I have prepared a brief summary of these programs for your review. It is attached to my prepared statement.

In Massachusetts, each congregate facility has a coordinator who recruits applicants, screens and assesses their needs, arranges for services needed by residents, facilitates group activities, and integrates the residents into the community.

A recent study of the program has shown that 85 percent of the residents receive health and social services in some form. Social services include homemaker, personal care, chore services, counseling, transportation, day care, and case management. 67 percent of the residents receive homemaker services.

Along with the quality of life, the cost of congregate housing scores very well. It is cheaper to build congregate units than traditional elderly housing. As the thousands of elders living in Federal housing units grow older and more frail, congregate housing should become a Federal housing priority to meet their changing needs.

Congregate housing offers a real alternative to nursing homes. Massachusetts has an above-average supply of nursing home beds that cost medicaid between $13,000 and $18,000 a year.

Eighteen percent of our congregate residents came from nursing homes, and their cost of care dropped 20 percent in the congregate facility.

For all residents, the average cost of social services was $1,500 per year, and the average cost of health services was $1,300 per year.

As it is in level III nursing homes, the major costs of congregate housing is the cost of housing itself. The congregate housing, with community services provided as necessary, is less costly than nursing home care.

Program administrators, policymakers, and providers alike know that the lack of adequate housing is a major reason why many seniors enter nursing homes. Our experience with our State home care program, with the National Channeling Demonstration Program, and the medicaid waivers that fund community based services shows clearly that vulnerable people can live in the community and that congregate housing is one very successful model.

But once we have the supply of congregate housing, where will we find the money for services? The funds to support community services are there in our medicare and medicaid programs. I must say that in Massachusetts, we've put millions of dollars in State moneys in those services, but for the rest of the country we're really going to have to look to, and I hope build on medicare and medicaid to provide this service money.

The costs of these programs are rising dramatically and they are driven in part by the rising costs of institutional care. Community care helps divert people from institutions. We should change our medical programs to fund the services that people need to stay in the community.

Senator Heinz has filed the Health Care Coordination Act which would allow States to spend both medicare and medicaid funds on the range of services that our programs show have been effective in keeping vulnerable people in congregate housing and out of nursing homes.

This is the direction we should take. We pay huge sums for nursing home care and other health care services that could be used to support people in congregate housing.

In this State, we're spending about $600 million a year, of State and Federal money in institutional care: Nursing homes, rest homes, and chronic care hospitals. We're spending about $100 million in community care.

Our Nation's elderly in public housing are growing older and more frail. We now support them through section 8 and State subsidized housing. Without congregate housing and without models like the Health Care Coordination Act, we will care for them in nursing homes.

We cannot rely on nursing homes exclusively to deliver this care. We must broaden our programs to enhance and maintain the quality of life for our people. We must alter our programs in a way that makes both programmatic and economic sense.

I'm delighted that you've come here to really publicize and look at the programs of congregate housing that we have in Massachusetts, because I think they're good programs.

Thank you very much, Senator.

Chairman HEINZ. Secretary Rowland, thank you very much. Your statement will be placed in the record at this point.

[The prepared statement of Mr. Rowland follows:]

PREPARED STATEMENT OF RICHARD H. ROWLAND

Mr. Chairman, the Commonwealth of Massachusetts has recognized the need to provide suitable living arrangements for elders who require supportive services to remain independent. However, there are many elderly persons who require more than just coordination of supportive services to maintain independence. Some older people may need more social interaction to combat isolation. Others may be inappropriately institutionalized but feel unable to cope with totally independent living. Still others desire the style of living offered by shared apartments. For varying reasons, older people need a variety of living arrangements. One of these living options is congregate housing.

To meet this need, the Executive Office of Commmunities and Development, the Department of Elder Affairs, and the Department of Public Welfare have developed and implemented a State congregate housing program for elders. The State-funded congregate housing program was designed to address the needs of those elderly persons who can live independently, if provided certain health and social services, and an environment that prevents the isolation that older people experience so often.

We define congregate housing as a noninstitutional, residential shared-living environment that integrates the shelter and service needs of the functionally impaired and/or socially isolated elder who does not require the constant supervision and/or intensive health care provided in an institution. This shared-living environment includes at least two of the following: (a) shared community space, (b) shared kitchen facilities, (c) shared dining facilities, and (d) shared bathing facilities. Congregated housing, therefore, is a generic term used to describe a shared-living environment designed to integrate the shelter and service needs of elders.

The goal of congregate housing is to assist elders in maintaining an independent lifestyle through the provision of supportive services, and thus avoid unnecessary or premature institutionalization.

Congregate housing is neither a nursing home nor a medical care facility. It does not offer continuous supervision of residents. Those services which are made available should be designed to aid residents in managing the daily activities of independent living, and should be provided on an "as needed" baisis, thereby avoiding unwarranted dependence on supportive services. Congregate housing, therefore, functions to (1) meet the basis shelter and service needs of elders, (2) assist elders in maintaining their independent lifestyles, (3) provide a viable residential option to fill the gap between totally independent and institutional living environments, and (4) offset the social isolation so ofter experienced by elders.

Secretary Anthony has described the shelter component of congregate housing. The services provided to congregate residents on an as needed basis are of our social and health services available in the community. Services providers included the home care corporations, local home health agencies or visiting nurse associations,

councils on aging, mental health clinics, and other elder services or commuity service agencies. The home care corporations offer nine core services: Homemaker, chore, transportation, case management, protective services, information and referral, companionship emergency shelter, and home-delivered meals. Home care corporations offer other services as well. These services vary from location to location and may include health, laundry, social daycare, and other advocacy assistance.

The visiting nurse associations or local home health agencies provide nursing, therapeutic (physical, occupational, and speech therapy), and home health aide services to persons requiring such health services at home. Other service providers typically offer recreation, transportation, and chore services. In many communities, congregate meals programs are available. In some location, these are provided at congregate housing facilities. Other services, which may be available, include adult day health programs, employment, and mental health services.

Supports received by congregate housing residents can be formally provided by a service agency and congregate project staff and/or informally provided by family, friends, volunteers, and other congregate residents. Services vary in number and frequency but tend to come from the following list:

—Community nutrition program held at the site.
—Community nutrition program run at a nearby location.
—Cook who prepares group meals in the congregate housing facility.
—Meals-on-wheels (home delivered meals).
—Homemaker prepared meals.
—Homemaker services.
—On-site mental and/or physical health clinic or consultation.
—Nearby mental and/or physical health clinic or consultations.
—Community transportation specifically for the elderly between the congregate and such places as the community center, doctor's office and shopping areas.
—Adult day health care.
—Trips and other recreational activities organized through community agencies.
—Companions or friendly visitors.
—Home health aides.
—Physical, occupational, and speech therapists.
—Chore workers.
—On-site security person.
—Presence of nonservice staff with concern for the congregate, such as housing authority management and maintenance staff who chat with residents about their daily activities or problems.
—Support from family members, sometimes coordinated by the service staff; and
—Mutual support among residents.

Each congregate facility has a coordinator who manages the service component and coordinates the delivery of supportive services to the residents.

The coordinator draws upon any and all local services to develop an integrated package of supportive services, which meet the needs of the residents. The coordinator is also responsible for interviewing and assessing prospective residents, recruiting applicants through community education and outreach, developing and maintaining tenant records, facilitating group interaction, and integrating the congregate facility into the community. The congregate housing coordinator's position and related support cost (telephone, printing, mailing, travel) are financed by funds from the Department of Elder Affairs.

When our program was developed, the target population for congregate housing was defined as those most at-risk institutionalization or those inappropriately institutionalized. However, the intent was not to preclude socially isolated but healthy persons with few service needs, who may desire a shared-living environment, from choosing congregate housing. Rather, it is felt that a mix of both physically well elderly needing and/or desiring a shared-living environment and frail elderly needing the supportive services of congregate housing, would be ideal in fostering an atmosphere of sharing and mutual interdependence.

A research project conducted by the Department of Elder Affairs, and Building Diagnostics, Inc., found that congregated housing is an effective non-institutional living option for many older persons in need of the supportive environment and shared-living. Residents of congregate housing span a wide-range of physical, emotional, and social characteristics whose mix in this type of housing allow residents to benefit from the formal services available and the special informal support gained from the shared-living arrangement. In fact, some congregate housing residents require no formal support services. For this group, the informal network of family support and mutual resident sharing—coupled with the relief to not being alone should any difficulties arise—is sufficent support.

The Department of Elder Affairs has just completed a detailed analysis of the efficiency and effectiveness of State-funded congregate housing as a noninstitutional shared-living environment. Congregate housing presents an alternative to the problem of costly and unnecessary nursing home care by providing a housing option to fill the gap between totally independent and institutional living environments.

For the 21 residents of nine congregate facilities who moved to congregate housing from an institutional setting, the actual costs of providing them with shelter and services in the congregate unit was compared with the costs of providing them with shelter and services in a level III nursing home. For all but two of the previous nursing home residents, their shelter and service costs were lower in the congregate setting. The average cost of shelter and services in the congregate setting for those persons who had previously resided in an institutional setting was $880 per month compared to a monthly nursing home cost of $1,116.

In addition, congregate housing in Massachusetts achieves a cost savings in home care services by providing a single service delivery site for many clients. For eight of the nine State-funded congregate housing facilities looked at in our analysis, the average amount of homemaker hours per client was lower for the clients living in congregate housing than for clients living in the community. Most facilities tried to be creative in the use of homemakers. The coordinators and provider agencies attempted to use the same one or two homemakers depending on the size of the facility. Some also made an effort to assign tasks rather than people to the homemakers. The homemakers themselves tried to be creative in the use of their time by shopping and cooking for more than one person at a time. Furthermore, by cleaning the common areas of a congregate apartment such as a kitchen or bathroom, the homemaker was servicing more than one person at a time.

Why should the Federal Government become involved in the integration of shelter and services?—First, the elderly represent an increasing percentage of the Nation's population. The 1980 census reported 25.5 million persons 65 years and older. By the year 2000, persons 65+ are expected to represent 13.1 percent of the population, and this percentage may climb to 21.1 percent by 2030. Furthermore, the elderly are living longer than ever before in generally better health. Persons aged 75 and over are making up a growing proportion of the Nation's elderly population. In 1900, the 75 and over age group represented 29 percent of the 65 and over population. In 1975, that same group represented 37 percent of the 65+ population. In Massachusetts, the total elderly population grew 14 percent while the over 75 population grew 20 percent in the years 1970 to 1980. These older but still but still relatively healthy elderly persons are capable of maintaining independent lives with the provision of supportive health and social services.

Second, there are few housing alternatives to totally independent living situations on the one hand and skilled nursing facilities on the other hand. Therefore, it is essential to have housing alternatives like ours to bridge the gap and meet the shelter and service needs of functionally impaired and/or socially isolated elders who do not require the constant supervision or intensive health care provided in an institution.

Third, the integration of shelter and services is especially important due to the economic and social costs associated with intermediate care and skilled nursing facilities. Evidence of premature and unnecessary admission, of costly overutilization of services, and of the negative impact of these environments on the morale and capacity to function independently of an older person who does not need the intensive health services and protective oversight provided in an institutional setting has stimulated the need for less expensive alternatives. As stated previously, the Massachusetts model of congregate housing can serve as a less expensive shelter and service model for some other people.

Fourth, congregate housing can enhance an older person's quality of life by allowing them to maintain independent and meaningful lives. The shared-living feature of publicly-funded congregate housing in Massachusetts provides a supportive environment and promotes independence through interdependence.

A final but very important reason for the critical need of shelter and service integration is due to the aging stock of public housing. The Federal Government has been building housing since the 1930's and 1940's. The Commonwealth of Massachusetts has been constructing public housing since 1954. Older people who may have entered public housing when they were in their sixties may not be in their eighties. These public housing residents are becoming older, more physically and emotionally frail, and more socially isolated. Without the integration of shelter and services, these older public housing residents may be forced to seek more costly institutional care.

While Massachusetts with its well developed care program and public housing program has developed a congregate housing program which can serve as a model for shelter and service integration, most States would be hard pressed to replicate this model without Federal assistance. Very few States have as well a developed home care program in Massachusetts or as extensive a network of social and health services. Even fewer States have their own public housing programs. Furthermore, there are thousands of elderly units subsidized by the Federal Government in Massachusetts where this model of shelter and service integration is not in place due to the limited resources of a state as opposed to the Federal Government.

Senator Heinz has filed the Health Care Coordination Act, which would allow States to spend both medicare and medicaid funds on the range of services that our programs show have been effective in keeping vulnerable people in congregate housing and out of nursing homes. This is the direction we should take. Instead of paying large amounts of money for nursing home care and other intensive health services, Federal and State governments should be using those funds to support people more cost effectively in congregate housing. Models like congregate housing and the Health Care Coordination Act can enhance and maintain the quality of life for our older people. These innovative models make both social and economic sense.

In summary, congregate housing is a living arrangement suitable for a broad range of older people including those who desire security and companionship, those who want to exercise control over their own lives, and those who need to build up confidence before moving to an even more independent living environment. Congregate housing is one of a variety of housing options for older people. However, it can be the preferred option for some people because it offers service coordination and the social support, companionship, and security of living with other people.

The State-funded congregate housing program in Massachusetts presents an excellent model of interagency coordination between housing, social service, health service, and management service providers at both the State and local level. This spirit of cooperation and communication among housing and service agencies should be imitated in other elderly housing agreements.

Survey of Congregate Housing Programs in Other States

VERMONT

The Vermont Office on Aging has established congregate housing demonstration projects at three locations in Vermont: Essex Junction (20 units), Manchester (18 units), and West Townshend (10 units). "Congregate housing" means residential living with support services which include shelter, nutrition, housekeeping, and personal and social services in a facility containing independent apartments and a common dining room. Possible expansion to two more sites.

Not all residents at these three locations receive congregate services. Model includes a "site coordinator." Services are reserved for those people in "some stage of frailty requiring special assistance." All three locations are developments funded by HUD. Congregate housing services provide supportive services to the more "frail" tenants of subsidized housing, thus enabling them to remain independent in their own apartments. The supportive services offered through this program include meals, transportation, personal services, light housekeeping, and administrative support services. Services are provided above and beyond what already exists. For example, a noon meal may be provided at a community meal site. This program would provide evening or weekend meals and other services such as personal care, transportation, and homemakers. The goal is to try to insure that a person can remain in their own apartment with supportive services.

MAINE

Two demonstrative programs, one urban and one rural.

Definition of congregate housing—noninstitutional shared living environment which integrates shelter and service needs for the functionally impaired or socially isolated elderly who do not require the constant supervision or intensive health care of an institution. The shared living environment includes community space and dining facilities.

Financing for the congregate housing development will be from the Maine State Housing Authority or from the Farmers Home Administration.

Each congregate housing services program shall have a case manager who demonstrates competence in and will be responsible for the overall management of the delivery of services to congregate housing services program (CHSP) participants.

Each CHSP shall have available the following "core" services: (a) Meals, (b) housekeeping/chore services, (c) personal care assistance, and (d) transportation.

In addition to core services, each CHSP must provide through the case manager access to a mix of other benefit programs and community services which CHSP participants may need. Such services may include: assistance securing benefits (food stamps, insurance claims, SSI, etc.), escort services, health services, including dental care, counseling services, legal services, recreation, etc.

MARYLAND

Sheltered housing for the elderly means a form of residential environment consisting of independent living assisted by congregate meals, housekeeping, and personal services, for persons 62 years old and older, who have temporary or periodic difficulties with one or more essential activities of daily living like feeding, bathing, grooming, dressing, or transferring.

The critical differences that distinguish sheltered housing from other forms of housing for the elderly are:

(1) It has as its goal the support of independent living and the prevention of unnecessary institutionalization of older people who need services but are not ill.

(2) It is residential rather than institutional or medical in character, and is located in residential neighborhoods in close proximity to transportation and community facilities.

(3) It provides a housing arrangement in a supportive environment as well as shelter.

(4) It is directed to those older persons who, with advancing age, experience decreased energy and mobility but who retain the capacity and desire for normal living and as much self-management as possible.

(5) It makes available a basic level of quality of service for meal service, housekeeping and personal services, as needed, leisure activities, and other services which provide assistance with activities of daily living and promote sociability.

(6) It provides individual dwelling units with bathroom facilities and living space. They may or may not contain cooking facilities.

(7) It contains common spaces such as a lobby, central kitchen, common dining area, and indoor and outdoor activity spaces.

(8) It has a management staff who perform social, environmental, and service functions as part of the housing management.

(9) It provides 24-hour security.

NEW YORK

Enriched housing shall mean a type of residential care for adults in which those elderly, who are functionally impaired, but not in need of continuous medical or nursing care, are provided lodging and a systematic program of supportive services, including meals, housekeeping, personal care and case management in a small group living arrangement by a public or nonprofit sponsoring agency according to a plan approved by the New York State Department of Social Services, in order to enable them to continue living within the community, with a maximum degree of independence and privacy.

A public or norprofit sponsoring agency will be responsible for selecting the residents, securing suitable housing, and providing the required supportive services.

The programs will make use of existing housing within regular residential buildings or publicly subsidized housing, including buildings for the well elderly. Various arrangements are possible such as shared multibedroom apartments or combinations of individual dwelling units in close proximity to each other (e.g., a cluster of efficiency units). In all cases, only a small portion of the units in any one building or apartment complex can be devoted to enriched housing in order to preserve a noninstitutional environment.

Eligibility for residence in enriched housing will be limited to the functionally impaired elderly who do not require continuous nursing or medical care, but who, without basic support services, would be unable to live independently.

To summarize, enriched housing programs will incorporate these four essential features:

(1) Clients will have the security of being able to rely on a single source for assuring the coordinated provision of needed daily services.

(2) Services, and to some extent living space, will be shared by a small group, thus lowering the costs of providing care outside an institutional setting. At the same time, the loneliness and fear of living alone will be reduced.

(3) The residential units will be fully integrated among ordinary housing within the community, thereby avoiding isolation from the mainstream of society, friends, relatives, and familiar places.

(4) The values which are the essence of independent adult life will be preserved: opportunities to exercise choice, to maintain personal autonomy, to live with privacy and dignity, and to avoid unnecessary dependency.

CONNECTICUT

The congregate housing for the elderly program was enacted into law during the 1977 session of the Connecticut General Assembly. The intent of this program is to provide housing for eligible elderly citizens who, because of infirmities and other functional limitations, cannot live in a completely independent environment such as that which DCA's conventional elderly housing program provides through local housing authorities. In addition, these citizens do not require the extent of care or supervision that is provided in a nursing home or other care institution. Congregate housing structure provided by DCA, with independent living assisted by congregate meals, housekeeping and supporting services provided through the Department on Aging is the means by which alternative housing can be provided for less independent senior citizens without resort to institutionalization such as a nursing home.

The congregate housing for the elderly program provides funds for the acquisition of property, the demolition of existing structures and the construction, reconstruction, alteration and repair of existing structures in conjunction with a congregate housing program. The State program of congregate housing for the elderly as administered by the Department of Community Affairs provides a direct grant, interim loan, permanent loan or any combination thereof to a municipal housing authority or a community housing development corporation. State assistance may take the form of a loan when the Federal section 8 housing assistance payments program is available. There is a sheltered housing manager who has responsibilities similar to our congregate housing coordinator.

NEW JERSEY

Congregate Housing Act of 1981, which provides money for tenants in need of some support services who are living in subsidized housing in New Jersey. Financed with casino revenue funds, the program is administered by the division on aging through grant agreements with housing sponsors.

Services in the congregate housing package are those which the occupants cannot or do not wish to provide for themselves and those which are not already supplied by the housing sponsor. The congregate services program provides subsidies for: one or more daily meals, housekeeping, and personal care assistance. The objective is to extend and enhance the length of time an elderly person can live an independent lifestyle.

The program requires that part-time coordinators arrange for proper delivery of services. The coordinators may also provide some direct services that are not available in the community. In 1981, the program was operating in eleven projects. One hundred and sixty people were enrolled in various aspects of the program.

OBSERVATIONS

All involve the notion of congregate housing being the integration of shelter and services.

Maryland and Connecticut appear to use State money to construct housing, the other States do not.

The programs in Vermont, Maine, New York, and New Jersey appear to be modeled after the HUD congregate housing services program where extra services are provided to some residents in a traditional elderly development who might otherwise be forced to move to an institution.

All the other programs seem to use a coordinator type person.

The existing community services do not appear to be as well developed as in Massachusetts.

Chairman HEINZ. Again, I'm going to reserve questions until Secretary Abrams has finished his testimony. Let me just say by way of introduction of Phil Abrams, the Under Secretary of the U.S.

Department of Housing and Urban Development, that we are indeed privileged not only to have a man of his experience and ability, but also one who is a native Bostonian. And, those of us who aren't privileged to come from Boston or Massachusetts are only slightly jealous of the careful attention that he has paid to the housing needs of both Boston and Massachusetts.

And we don't accuse him of favoritism, at least publicly. But, Phil, you are a man of great expertise, great integrity, and we are delighted that you are here in Boston, and we appreciate your joining us not only this morning, but also this afternoon.

Please proceed.

STATEMENT OF PHILIP ABRAMS, WASHINGTON, DC, UNDER SECRETARY, U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Mr. ABRAMS. Thank you, Mr. Chairman. I have a statement I would like to submit for the record.

Chairman HEINZ. Without objection your complete statement will be made a part of the record.

Mr. ABRAMS. It's a pleasure to be with you again and continue our discussions, both in your capacity as chairman of the Special Committee on Aging, as well as in private conversations concerning the elderly and elderly housing.

I know how interested you are and how your interest has made you the leading spokesman on these issues in the Congress.

So I'm delighted to be here today in my home town to be able to testify on some of the things that are happening in HUD and some of our observations about housing for the elderly, and particularly housing for the elderly involving residents who are "aging in place."

Early in his administration, President Reagan convened the White House Conference on the Elderly. That conference reached several conclusions that are the basis for many policy decisions within the administration, not the least of which was that the elderly are a diverse group and that diverse solutions are needed in order to come up with the proper types of housing for the different segments of the elderly community.

Fortunately in our country, the number of elderly people in physically inadequate buildings has declined and is continuing to decline, however we have to continue to work at this to continue that trend.

Also, thankfully, the number of elderly people in our country are increasing, and that means we have to continue to expand the types of options that are available.

For those people who do not need subsidies, the Federal Housing Administration provides insurance programs, under various titles, that provide for market rate rental and home ownership dwellings for the elderly. One of those programs was expanded December 28, 1983 to include retirement service centers, so that, for the first time in market rate elderly housing projects, you can combine services like congregate services with housing services under one insurance program.

And we've had a tremendous amount of activity, particularly in the southeastern United States, and I hope we're going to be able to expand that activity to New England.

We have also for the first time begun insuring homes in retirement villages. With the passage of the Housing Act of 1983—which I know you worked on very closely, Senator—we got the authorization to have manufactured home parks exclusively for the elderly.

We have talked about reverse annuity mortgages, and in response to your initiative, President Reagan proposed a demonstration of FHA insurance for reverse annuity mortgages or home equity conversions. The Housing Act asks us to study that process which we will do and report to the Congress in November of this year.

We've been looking at several other options: Home ownership for empty nesters can be facilitated by communities changing their zoning and other laws so that we can utilize accessory apartments in houses. One of the things that's very important that came out of the Housing Act of 1983 is our ability to now insure board and care facilities, or in Massachusetts terms a level IV rest home, under the Federal housing programs.

Before this we could only insure medical facilities.

We now have clearance from our general counsel's office to combine insurance for rest homes and elderly apartment buildings so that we will be able to insure, for the first time, life care centers with even more extensive care available than we are able to provide in retirement service centers.

But I think we have to address that segment of the population that needs subsidy, and those low-income elderly families that need to rely on Federal, State, and local programs to help them with their housing affordability problems.

Forty percent of current section 8 certificates or vouchers are utilized by low-income elderly households; that's 40 percent of 767,000 certificates used throughout the country.

What is so attractive about that program for one segment of the elderly community, who are able to live independently and without any great need for services, is that they can stay in place. They can stay in the apartment or the house where they have been living, and they don't have to move, but they can get Federal assistance for their affordability problems so that they can afford to stay where they have been living.

This week we announced the distribution of funds for the rental rehabilitation program. And that program will provide money to the city of Boston and to the State of Massachusetts to rehabilitate existing buildings—single family houses, two- and three-family houses, apartment buildings—so that substandard buildings—and I think a lot of the housing problems in the city of Boston is a matter of rundown housing stock which can be saved—can be brought up to safe and decent housing standards.

This program just announced, and which we expect to be funded when the Senate comes back next week, is going to be a tremendous resource for low-income families that need housing assistance.

For the first time in the Housing Act of 1983, we have legislative authorization to provide shared housing under our programs. And we've been talking about definitional terms between congregate

and shared housing. Shared housing is defined in terms of people living in a unit without their own kitchen and their own bathing facilities. It is now capable of being provided under the Federal programs for the first time, and we are changing our regulations and hope this summer that we will be able to provide shared housing in our 202 program and all the HUD programs.

That 202 program is one of our main resources for helping the elderly, and particularly the frail elderly and the handicapped. President Reagan has proposed for 3 years, and Congress has appropriated money, to expand that program for the elderly and the handicapped. We have had a great deal of success in Boston. I had the pleasure of meeting the representatives of two projects that the Archdiocese of Boston is going to start construction on soon, for elderly and handicapped households, as well as representatives from the Combined Jewish Philanthropies who have a project under construction.

That program will provide 14,000 additional housing units in 1984, and is our principal program in providing additional supply of new housing for the elderly.

Public housing, as we noted this morning, has over 500,000 units for the elderly throughout this country. The Boston Housing Authority surprisingly has a need for more applicants for elderly housing throughout their projects in the city of Boston. We have been working to assure that all of the Federal units in Boston that have been uninhabitable for the last several years are being brought up to safe and decent housing standards. And the housing authority now has enough Federal funds to bring every public housing unit into occupancy within the next 2 years.

Our community development block grant program and the urban development action grant program also provide funding sources for services to the elderly as well as providing funds for senior service centers, life care centers, and other development projects.

But looking specifically at the issue of aging in place as you've directed our attention today, Senator, many of the services required really go beyond the provision of housing. For most projects, including the two we looked at today, the principal problem isn't one of space; the principal problem is one of providing services.

The principal resource for those services is the Department of Health and Human Services, particularly with programs appropriated under the Older Americans Act. HHS provides block grants to States throughout this country for meals, support services, homemaking services, health services. In fact, the administration is proposing this year that the Older Americans Act consolidate all of these block grants and authorize and appropriate $773 million for 1985 for the AOA programs and to provide for 3 years of authorization of those programs which will allow people to plan ahead with the assurance of 3 years of authorization ahead of them.

There is a tremendous need in the housing staff of these buildings for an awareness of what community services are available and an ability to coordinate the staff, particularly the management staff in these projects, so that they can access these programs that are available through Federal grants to the State.

And we have been stressing in our manager's training and our certification for managers of HUD buildings, a knowledge and an ability to coordinate and gain access to these programs.

I think that that is an important part of your proposed legislation, Senator, in terms of increasing the capacity and the ability to coordinate the programs that are available so that every elderly household that needs support services can avail themselves of them.

We have been conducting a congregate services program for the last several years. We will be issuing a report by the end of this year through our contractor. We have 63 projects that have a variety of congregate services facilities available, and we have made several conclusions: First of all, that on a preliminary basis, it is very important that as we provide congregate services for the elderly, and particularly the frail elderly, that we target our resources to those people who need them and we tailor the services available to the people who are living in the building, not just provide all services to all people.

Because in doing that we can avoid duplication and we can avoid having several programs overrun each other, and not properly utilize existing resources. But more than anything else, our conclusion is that congregate services and the providing of health and home care services for people who are living in elderly housing is a far superior alternative to institutionalization, either in nursing homes or in other facilities, that we must look at ways of improving the provision of those services so that we can keep elderly people in elderly housing where they are happier, where they have a more fulfilling life, and where it is more sensible from a planning point of view, from the taxpayer's perspective.

So, we're looking forward to this final report, and looking forward to action by the Congress on the amendments to the Older Americans Act that you proposed, Senator, and continuing to make HUD's programs work for all elderly throughout this country. Thank you, Senator.

[The prepared statement of Mr. Abrams follows:]

PREPARED STATEMENT OF PHILIP ABRAMS

Mr. Chairman and members of the committee, I am pleased to appear before you today to discuss HUD's programs and activities to serve the elderly. The administration and the Congress share the concern that we maintain and improve the quality of life for older Americans. Before I address the specific issues of concern to the committee in this series of hearings, I want to describe some of the actions HUD has taken to help the elderly.

Over the past several years, the overall housing conditions of the elderly have improved significantly. The proportion of all elderly households in physically inadequate housing declined from 14 percent (or 2.4 million) in 1975 to 10.5 percent (or 1.8 million) in 1981. Very low income elderly households are somewhat less likely to live in inadequate housing than all very low-income households. However, while housing availability is generally no longer a problem, housing affordability continues to be one. Therefore, the administration has focused its housing initiatives for the elderly on programs designed to make housing more affordable.

First, our continued commitment to the section 8 certificate program and our implementation of the newly authorized housing voucher program benefit elderly families by allowing them to receive housing assistance without moving. Under the previously funded section 8 new construction program, elderly families had to move from their homes into projects in order to receive assistance. As of December 31, 1983, 40 percent of the approximately 767,000 units made available under the section 8 certificate program were occupied by the elderly. In addition, the Housing

and Urban-Rural Recovery Act of 1983 permits shared housing for the elderly under the section 8 certificate and moderate rehabilitation programs. Publication of shared housing regulations is one of our high priorities, and we expect their development to progress quickly over the next few months. The same regulations will allow us to assist families in shared housing arrangements in all of our assisted housing programs, including the new voucher program. The benefits of shared housing include companionship, security, and reduced housing costs. Another use now authorized for section 8 certificates and vouchers is single-room occupancy housing.

Second, even though the administration will rely primarily on existing housing in its housing assistance programs, because of the prohibitively expensive nature of new production programs, the administration continues to recognize the special nature of and unique need for housing designed for the elderly and handicapped. HUD continues to request appropriations for the section 202 program. Beginning in fiscal year 1982, the administration instituted several cost containment measures for the program including reducing unit square footage, limiting units to efficiencies and one-bedrooms, requiring that 25 percent of the units be efficiencies, requiring that the buildings be of modest design, and restricting the space not attributable to dwelling units to 10 percent of total space. Because of these cost containment measures, we have been able to reduce per unit costs, thus permitting more units to be constructed with the funds available. Further cost savings are occurring as a result of our regulations mandating competitive bidding for projects now under development. In addition, we are now permitting the construction of section 202 projects adjacent to section 232 and conventionally financed nursing homes, which has the effect of creating life-care facilities.

Third, HUD is implementing the congregate housing services program (CHSP) demonstration. Under this congressionally authorized demonstration, HUD provides multiyear grants (3 to 5 years) to PHA's and nonprofit 202 sponsors for meals and other support services to frail elderly and nonelderly handicapped residents. The objectives of the congregate housing services program are: (1) To prevent premature institutionalization; (2) to encourage the improvement of support service delivery; (3) to fill the gaps in existing service delivery; and (4) to coordinate with other Federal programs in order to avoid duplication. Since 1979, a total of $24 million has been appropriated to carry out the demonstration in 63 projects. An evaluation of the program is currently underway, with a final draft report due to HUD on December 31, 1984. I will discuss what we have learned so far from this evaluation later on in my testimony.

Examples of other HUD programs which benefit the elderly are:

—Section 231 mortgage insurance for elderly housing is HUD's principal program designed solely for unsubsidized rental housing for the elderly. Congregate housing projects can also be insured under this section. In fiscal year 1983, nine projects, with 1,708 units, were insured.

—The section 221(d) (3) and (4) mortgage insurance programs also insure projects for the elderly and congregate facilities. HUD has recently created the retirement service center program as an expansion of the services offered under the (d)(4) program. Retirement service centers eligible for FHA insurance are market-rate residential rental projects which include meals served in central dining facilities and services such as housekeeping and weekly laundering of linens. These centers help bridge the gap between totally independent living in noncongregate housing and nursing homes. There has been a great deal of local interest in developing these centers.

—Section 232 insures nursing homes and intermediate care facilities. In fiscal year 1983, 62 facilities providing 8,972 beds were insured for a total of $262.3 million. The 1983 legislation, in response to specific needs in certain local areas for a wider variety or combination of care levels, expanded section 232 to authorize insurance for "board and care" facilities. Board and care homes will have units with shared bedrooms and bathrooms, along with central kitchens.The facilities will have no medical component, but will have 24-hour staff for continuous protective oversight of residents. When regulations are published to implement this amendment, it will be possible to insure one section of the act. This will permit a wider range of facilities, both singly and in combination, for the elderly and will permit various levels of residential and health care in complexes for elderly people.

—As a result of a White House initiative, FHA single-family insurance can now be used for retirement villages exclusively for the elderly.

—At the request of the administration, the 1983 act now permits mortgage insurance under section 207 for manufactured home parks exclusively for the elderly.

—While it is impossible to estimate what portion of CDBG funds are used in ways which address the needs of the elderly, we do know that a significant portion of this funding benefits them. Many communities use their CDBG funds to help the elderly make home improvements or weatherize their homes. CDBG funds have also been used for senior citizen centers. In fiscal year 1982, information voluntarily submitted by States on their small cities CDBG programs showed that public facilities and improvements among small city grantees included at least 18 senior citizen center projects receiving an average of more than $50,000 in CDBG assistance.

—Since 1978, 79 UDAG projects have been awarded for activities which specifically benefit the elderly. Examples of projects funded in 1983 include construction of a geriatric center which will include both health facilities and apartments; conversion of a old high school into a nursing home and conversion of an existing facility to a community care home.

—In 1982, 757 section 312 loans, totalling $49.4 million, were made. Although there are no data available on the ages of loan recipients, if the patterns of previous years are followed, approximately one-sixth of these loans were made to elderly homeowners.

—As of September 1983, approximately 514,000 units of public housing, or 43 percent of the total stock, were occupied by the elderly. PHA's can also develop congregate rental housing for the elderly and handicapped. This congregate housing differs from conventional public housing in that the individual living units may not have individual kitchens. Instead, these projects must have a central kitchen and dining facility to serve communal meals. Support services may be provided by the PHA's, but most are provided by local social service agencies.

—In 1983, the administration requested that Congress give HUD the statutory authority to insure reverse annuity mortgages on a demonstration basis. Instead, the 1983 authorization act directs HUD to evaluate existing home equity conversion programs (also known as reverse annuity mortgages) and report to Congress by November 30, 1984. These programs are designed to help elderly homeowners remain in their homes by converting their equity into income to meet their increased housing expenses, make housing repairs or to meet other major one-time housing expenses. The Department will use the results of this report in determining whether to propose again a demonstration Federal insurance program for these mortgages.

—We are currently undertaking, with the Consumers Union Foundation, the preparation of a guidebook for the elderly and their families on how to make retirement housing choices. In addition, we recently issued a publication on how local governments can implement accessory apartment programs.

—Through our Joint Venture for Affordable Housing, we are promoting the removal of local regulatory requirements which prevent the construction of smaller, more affordable units for "empty nesters."

I now want to turn to a discssuion of some specific issues being addressed by the committee, particularly those issues concerning the extent to which the elderly who are living in nonmedical facilities are receiving support services adequate for their needs. My comments will focus on the following issues the committee is examining—the extent of "aging in place" in public housing; how to serve the frail elderly in federally assisted housing; how to improve the coordination of housing and support services for the elderly provided by the various levels of government; and proposals for changing the congregate housing services program.

"Aging in place" is a term used to describe elderly people who move into assisted housing and remain there even after they become frail. Although the Department has no current data on tenancy duration in assisted housing, which could be used to determine to what extent "aging in place" occurs, we can infer certain assumptions from the data we do have. Our data on the public housing population indicates that there has been some "aging in place." Approximately 33 percent of the elderly in public housing are between 75 and 85 years old and 7 percent are over 85—the age at which frailties are likely to become much more prevalent. Of the 7 percent who are 85 or older, we estimate that at least 70 percent "aged in place."

In addressing this problem, it is important to understand how services are currently provided to tenants. HUD is responsible for providing housing for eligible tenants and also for providing a climate which encourages various services to be made available—i.e., by permitting space within a project to be used for the delivery of services, by permitting staff to coordinate the obtaining and delivery of services, and by encouraging management to work with local service providers and service funding agencies to see that the appropriate services are available to residents.

In addition to public housing, HUD's section 8 program (including section 202 units) also provides shelter for large numbers of elderly people. The relationship between the Department and owners and sponsors of the privately-owned projects built under this program is very different from the relationship between HUD and the PHA's, which are local government entities established to own and operate public housing. Because of fundamental differences in ownership and HUD's relationships to the two kinds of assisted housing, the provision of services also differs between the two kinds of projects. As would be expected, HUD has fewer service-related requirements and less control in the privately-owned projects than in those owned by PHA's. HUD has no hard data on services provided in section 202 or section 8. However, many managers of these projects act to create a supportive environment for elderly tenants, by coordinating locally available services. These services are paid for by the tenants, rather than from the rental income. Project managers also frequently encourage and coordinate transportation services, for instance, county-funded buses to take tenants to and from medical and shopping facilities and recreation events. In addition, managers often encourage the availability within their projects of recreational programs such as arts and crafts.

HHS is the main Federal agency responsible for providing funds for these support services through the requirements of the Older Americans Act, legislation which is essentially concerned with removing barriers to economic and personal independence for older Americans. Because the Older Americans Act programs are administered by State and local agencies on aging, managers of HUD projects work at the State and local level to obtain funding for such services as title III meals and other support services including transportation, information and referral, homemaker and home health aides, and legal services.

HHS also provides funds to State and local agencies through block grants for health services for the elderly. For example, hypertension screening and a home health services demonstration are eligible activities under the preventive health and health services block grant. Community mental health centers can be funded under the alcohol, drug abuse, and mental health services block grant. Primary medical care can be funded under the primary care block grant. In addition, under two HHS categorical programs community health centers and home health care can be provided. The types of services available under HUD's congregate housing services program are eligible activities under these block grant programs.

HUD-assisted housing projects make use of the similarly broad array of services formerly available under title XX of the Social Security Act and now provided by social service block grants, as well as assistance provided by the Department of Transportation and others.

In 1975, Hud signed a memorandum of understanding with the Administration on Aging (AoA) and sent a notice to all housing authorities encouraging them to serve as sites for the AoA nutrition program. When we last formally surveyed the response to notice, in 1977, we learned that about a thousand public housing sites were hosting AoA-funded nutrition programs for their residents and for other elderly persons in the neighborhood. More recent informal surveys indicate that the number of sites has not decreased since 1977.

With regard to public housing, while we have not made an extensive survey of how PHA's in general provide service for their elderly residents, we do have some information about specific public housing programs. Let me describe a few of these.

Miami has many of its elderly residents participating in preschool and after-school youth programs as attendants, counselors, and teachers.

Also in Miami, $345,900 in property tax money from Metropolitan Dade County is provided to the PHA for a safety and security aid program. This consists of uniformed guards who monitor and police the projects 24 hours a day.

The Norfolk Housing Authority has live-in managers and 24-hour security in all of its elderly projects, to promote a sense of security among the elderly residents.

Fort Lauderdale provides a free plant nursery and garden program which is popular with its elderly residents, who often compete with one another over the appearance of their yards and gardens.

The Fort Lauderdale, Norfolk, and Miami PHS's have set up staffs with social work experience to coordinate locally-provided health and social services for their elderly residents, including meals, transportation, home health care, etc.

In New York City, a combination of $350.000 of Community Development money provided by the city and $1 million of title V funding from the Department of Labor provides a senior residents advisory program, consisting of an onsite live-in social worker living in each project where there are a significant number of elderly residents. The onsite worker helps the elderly residents link up with any needed services from home care to hospitalization.

Houston has a very successful program in which local corporations have "adopted" each of the elderly public housing projects. Corporation employees volunteer as housekeepers, game partners, entertainers, drivers, and general companions.

In a study of the well-being of elderly persons in Cleveland conducted in 1977, the General Accounting Office found that elderly people in public housing tended to be relatively well-served by local service providers who found it easier to focus their programs on public housing buildings rather than deliver them across a neighborhood.

We think that HUD is doing a very good job of seeing that services are provided in elderly public housing projects. However, the extent of services provided to elderly who live in nonelderly projects is unclear. We believe that there is no inherent problem in having the same level of services provided to this latter class of tenants. What may be needed is to help managers of nonelderly housing become more aware of the various service needs of their elderly residents and how such services can be provided. HUD requires that services and activities made available by PHA's to their elderly tenants also be made available to the section 8 certificate program recipients.

We also believe policies to improve service coordination must take into account the existing structure of the various Federal programs providing these services, rather than create new program structures. HUD's assisted housing programs are administered at the State and local level through State and local agencies and by private owners and sponsors. HHS' programs are provided through block grants to State and local governments. Federal agencies involved in providing services for the elderly should work to insure that the climate at the local level encourages coordination and that local officials and Federal officials at the field level know how to secure this coordination.

The Department's congregate housing services program, begun in 1980 on a demonstration basis, is an attempt to find the most effective solutions to the problem of obtaining services for the elderly in assisted housing. The demonstration, which is being conducted in both existing and newly constructed public housing and section 202 projects, provides full meal services plus those additional support services, such as housekeeping aid, personal assistance, or other support services deemed essential for temporarily disabled, handicapped elderly, or other handicapped persons to maintain independent living standards and aid in preventing premature institutionalization.

Residents who participate in the demonstration are selected by a project advisory committee (PAC) at each project which is responsible for seeing that services are provided only to those who really need them in order to continue living independently and to prevent premature institutionalization. The PAC is also responsible for insuring that participating residents get the specific services they need to continue living independently. We have recently taken steps to target the program better. Originally, one deficiency in the activities or daily living (e.g., bathing) was required for participation in the program. This requirement has been increased to two deficiencies, as of June 1983.

The Department is required to submit annual reports on the program to the Congress. In addition, an evaluation of the congregate housing services program is currently being conducted by our Office of Policy Development and Research through a contract with the Hebrew Rehabilitation Center for Aged in Boston. The evaluation is examining the impact of the program on institutionalization, hospitalization, and mortality rates, physical functioning and health status, whether the services are substituting for privately-provided services (from friends of relatives), whether the services match the needs (which is called "tailoring"), and whether the services are being targeted to the most needy. The evaluation will also examine the cost-effectiveness of providing these services. The contractor is required to submit the draft final report to the Department by December 31, 1984.

The contractor has recently submitted a draft report on targeting and tailoring. This report is currently being reviewed by HUD and will be sent to the committee as soon as the review has been completed. Preliminary conclusions show that the program is achieving its tailoring and targeting goals. There is a relatively high degree of targeting to tenants who need the services most, which demonstrates that CHSP projects actively initiated and carried out successful tenant assessment programs. Services provided also matched the services needed to a large extent. However, the program has not been entirely successful at restricting specific services to only those who needed them. The anecdotal information we have received from those agencies with CHSP grants shows that, when the program is well-targeted, it can be cost-effective, compared to other options, such as institutionalization.

These findings, while positive, are very preliminary and have not been placed within a necessary broader context. We have not yet received information on the cost of providing these services, nor on the relationship of these expenditures to specific program results. We expect to obtain this information in the final CHSP report at the end of the year. Once the final evaluation results are in, HUD will use them as the basis for recommendations on the future of the program.

There have been many proposals for changing the congregate housing services program, including turning it into a national entitlement program. Such a program could be very costly, could be duplicative of services already provided, and may not be a satisfactory answer to the problem. I urge the committee to await the final results of the evaluation before making any further changes in the program. As soon as the Department has completed its review of the final report, we will be happy to make it available to the committee.

We believe that there are currently sufficient programs to provide a coordinated package of housing and support services to the elderly. Insurance of board and care homes under the section 232 amendment will make it possible to insure, under one section of the act, both market-rate rental housing and nursing facilities. We hope it will be possible to combine the various HHS block grant programs with these facilities to produce complete packages of housing, support services, and medical care for our elderly citizens.

In conclusion, HUD is committed to improving the quality of life for older Americans and to insuring that their housing needs are addressed. We are actively exploring new housing opportunities such as retirement service centers and creation of life-care facilities through the location of different types of HUD insured projects in the same complex.

It is important to remember that HUD's programs are only one part of the administration's efforts to assist our elderly citizens. Overall, Federal Government expenditures for the elderly in fiscal year 1985 will total $257 billion, which amounts to 28 percent of the entire Federal budget.

Chairman HEINZ. Mr. Under Secretary, thank you very much for an excellent statement, and an excellent prepared statement as well.

Let me start our questions with Secretary Anthony, whose testimony about what you have been doing here in Massachusetts with congregate housing and the services provided to it, is really quite extraordinary. I think it's fair to say that you are leading the way. May I ask why you are so far ahead of the rest of the country?

Ms. ANTHONY. Well, I think that this State does have a long tradition of providing services and housing, particularly housing, for its elderly citizens. I think in some ways, because we have such a longtime commitment to elderly housing, and since that elderly population is aging, we are at the forefront of seeing the needs of an increasingly frail population.

As our 31,000 units of housing house increasingly frail elderly, we are facing within our own developments as well as in the population as a whole, issues that congregate attempts to deal with.

Chairman HEINZ. One of the members of our committee, Senator Chuck Grassley of Iowa, has on many occasions expressed a great deal of concern about, and held hearings on the particular problems of the rural elderly. Indeed, from time to time we get into discussions of how best to meet the needs of rural elderly in rural housing. Do your programs, as you've described them, work as well for the rural elderly as they do for the urban elderly?

Ms. ANTHONY. Yes, I believe they do. I think another reason why the program in the State is as strong as it is, is because we have the network of local housing authorities within many small communities across the State.

But for the programs that we run, 81 of the housing authorities that sponsor elderly housing under our programs are in communi-

ties of under 10,000 population; 16 percent, I believe, of all the units go to very small communities.

Of the congregate program, which so far has been a demonstration, 3 of the 18 congregate sites are in communities under 6,000 in population.

So I believe we are reaching out with the congregate program, and with applications received from 65 communities across the State, we will increase that service to rural areas.

Chairman HEINZ. Would you or would you not urge us to make any changes in our rural housing programs?

Ms. ANTHONY. We have found some difficulties in maximizing the use of Farmers Home Programs. That really brings me to one other point about the partnership between the State and Federal Government.

We have attempted to use State subsidy resources to increase the availability of Farmers Home rental housing in this State, and that has been difficult to do.

Chairman HEINZ. I think that is a subject for another hearing.

Ms. ANTHONY. I think so.

Chairman HEINZ. Secretary Rowland, with respect to the congregate cost data you provided in your testimony, have you compared the costs of congregate services to those in the level IV rest homes?

If so, what have you discovered?

Mr. ROWLAND. Well, we've looked at, particularly the costs of congregate housing and nursing homes, and there, the estimate is that of all the people going into nursing homes now, 5 percent could be diverted through the case management screening project through the welfare department, diverted simply because the need was just for housing.

That would affect really about 1,300 congregate housing units, if we had those units.

Chairman HEINZ. What is the per capita average cost of level IV rest home?

Mr. ROWLAND. For rest homes? If you go in a rest home, you're talking about $20 a day, as opposed to a nursing home that would run maybe anywhere from $38 to $45.

We have about 6,600 rest home beds in this Commonwealth, and we're finding that the operators of rest homes want to upgrade into a long-term care facility, because they would increase their cash flow.

We're also finding that the new case management screening project is really moving some people out of level III nursing homes into rest homes or level IV as they're referred to in this State.

The savings, if we were to look at congregate housing as opposed to nursing homes, and the case management screening project, would be between $3½ to $4½ million a year.

But you wouldn't find that differential in a rest home and a congregate housing facility. But the thing I would like to point out is our rest homes are really board and care facilities, where there is really not a large number of services built in.

The people that we're talking about in congregate housing need health and social services, and this is the crucial thing. We can provide health and social services with the shelter costs, and save money when we compare to nursing homes.

If you compare it to rest homes, you're going to get maybe a similar price, but you're comparing two different populations. The people in rest homes really don't get health and social services.

Chairman HEINZ. That was going to be my second question: Qualitatively, how much difference is there between a level IV rest home and what services are or aren't provided as compared to congregate services case management?

Mr. ROWLAND. Well, in a rest home, you wouldn't have services provided. I mean, you would have board and care, you know, room and board.

Chairman HEINZ. That's it?

Mr. ROWLAND. And that's the service. The other thing is that you would have maybe anywhere from four to six people sleeping in the same room. And so there is a whole issue of quality of life, and privacy.

I would point out that in the congregate facilities that we're talking about, in congregate housing everyone would have their own bedroom. And in almost every case would probably have their own full or half bath also.

What they would share would essentially be kitchen, dining and living facilities. In some cases they have their own kitchenette.

There is a difference in the quality of life in the rest home and in congregate housing.

Chairman HEINZ. If a rest home and congregate services case management operation cost about the same per person per day and yet a congregate services operation such as you have described provides more privacy, higher quality of life, and more services, how do you do it for the same cost? Why does one get so much more in congregate and get, in effect, less for the same price in a rest home? Where is the difference?

Mr. ROWLAND. Well, I think you have to look at the history of how things developed. Congregate housing really is more of a new phenomena, and you're going to hear from Pamela Shea-Roger a little bit later. You asked the question about how did Massachusetts get into this, and I think Pamela was probably the person that sort of moved us into that faster and really more heavily than any other person in the State, because she went and she perfected this concept at Norfolk House in Cambridge a number of years ago, and put it together through spit, bailing wire and paperclips.

But we have had board and care facilities in this State for a number of years, and those are licensed facilities now.

Chairman HEINZ. When did you first start licensing them?

Mr. ROWLAND. I couldn't give you the exact date. Phil says it was the late 1960's.

As we started to have more control over nursing homes through the medicaid and medicare, it was sort of a natural progression.

So in the late 1960's, we started to do that in Massachusetts. But as we move through the 1980's, we're going to see, probably, a decrease in the number of beds for rest homes because we're not paying very much.

And the economic thrust is for those operators either to upgrade and get more per diem, or really go out of business.

And it will be a shame because one of the things in this State, and I don't speak about it with any pride, is that as we deinstitu-

tionalized our mental facilities, we really pushed a lot of people out of our mental facilities and reinstitutionalized them in rest homes.

Now, I don't think we're much different from a lot of States. Partly we did this really to change funding streams, crass as it is.

But the thrust was to move people out and take advantage of a different funding stream. But I think that what you have here in congregate housing is something that grows out of a different need, and a different set of circumstances, and that is more privacy, bringing together health and social services, and as you look at the changing demographics in this State and the rest of the country, congregate housing fits. It's a concept for this time. And I think that the work that you're doing around the country on this, and the work that you're trying to do to bring together medicaid and medicare reimbursement for community services is really to be commended.

Because medicaid and medicare services are institutionally biased. They favor institutions, whether it's acute care hospitals, chronic care hospitals, or the nursing homes, and we're not spending nearly enough in a home setting like congregate housing.

Chairman HEINZ. And the recent changes in HHS regulations on intermittant care further exacerbate that by cutting back on the provision of home care.

Mr. ROWLAND. Yes.

Ms. ANTHONY. If I could add, Mr. Chairman, I think the other significant aspect about congregate care is the extent to which it fosters independence and mutual self-help. It doesn't simply substitute services in one place.

Chairman HEINZ. That was most apparent in the site visits this morning. There was a lot of community self-help among people as well as for people.

Let me ask for the record, Secretary Rowland, if you would do me a favor and supply projections of the annual cost savings for all congregate residents based on the 21 residents in the DEA study you mentioned in your testimony.

Mr. ROWLAND. Of course.

Chairman HEINZ. One other question for you, Mr. Rowland. Do you believe that the area agencies on aging should be more involved in the future than as a rule they are today in the provision of services in housing?

Mr. ROWLAND. Well, we have a unique situation in this State on the AAA's. We have 23 area agencies on aging, and in 20 of those AAA's, they're really also the home care corporation that delivers services to the 43,000 elders.

And so that in the majority of the 27 home care corporations you have 20 home care corporations that are very much involved in the function that you would be speaking about in terms of the coordination and dealing with the frail elders. Because that's their job.

I think in other parts of the country you have a different configuration. In Pennsylvania and New York I believe you use the county system a great deal for AAA's.

And if you look at it across the country you also sometimes see private nonprofit groups are functioning as AAA's. I think the wave of the future really involves no matter what the delivery agency is that it will be an agency that can do the planning, can do

the coordination and can do the demographic work that will point out how we're going to have to solve the problems of the 1980's and the 1990's. And that those AAA's—the dilemma is does their service delivery business get in the way with the planning and the advocacy kind of function? I think the jury is still out across the country on whether it does or not.

I think as more and more moneys come in to help people deliver services, the thrust will be to move in that direction. And I worry about that because that advocacy and that planning kind of function and that oversight function might be lost.

Chairman HEINZ. You're quite right; that is one of the tensions that has grown up. It could prove to be counterproductive or it could prove to be healthy. You're quite right.

Thank you very much, Secretary Rowland.

Phil, you and I know that there is a big difference between HUD's responsibilities and HHS's responsibilities and the latter's funding of medicare and funding of 50 percent or so of medicaid. In your view, following up on the question I asked Secretary Rowland, do you think a greater top down push for training and coordination between the AAA's and local housing authorities would be helpful as is intended in the first part of Senator Dodd's and my amendment?

Mr. ABRAMS. I think it would be helpful, Senator, and I think it would increase the amount of coordination between the agencies and it would benefit the people who are in elderly housing projects who aren't getting the benefit of the services available through HHS.

Chairman HEINZ. You cited in your testimony, written testimony, the exemplary work in Norfolk, in Fort Lauderdale, and elsewhere. Do those public housing authorities use HUD funds for services?

Mr. ABRAMS. Yes, sir.

Chairman HEINZ. Before I ask you about HUD's congregate housing program and your study of it, would you be so kind as to provide me for the record answers to two questions?

No. 1, we apparently have two different HUD figures for the number of elderly in Federal public housing projects; the 1982 data apparently is 650,000 and today's testimony is 514,000. So please clarify that difference for the record.

[Subsequent to the hearing, Mr. Abrams responded to the above question as follows:]

According to the data in the FORMS (field office management reports system) there were 514,383 public housing units occupied by elderly households on September 30, 1983. The figure in the annual report to the Senate Special Committee on Aging was obtained by applying the estimated percentage of occupancy by the elderly to the number of units in public housing.

Chairman HEINZ. Second, we would also like for the record whether you have any data on what the likely market is for section 221(d)(4) mortgage insurance for moderate income retirement service centers. If you could provide those, we would be most grateful. Will that be a problem to provide that information?

Mr. ABRAMS. We would be happy to provide that.

[Subsequent to the hearing, Mr. Abrams responded to the above question as follows:]

Judging by inquiries from developers and mortgage insurance applications submitted to our field offices, there is a limited market for the program in certain areas of the country. We have received applications in the Cincinnati, Indianapolis, Louisville, Richmond, Nashville, and Jacksonville field offices, and have had inquires in other field offices, including Dallas and Knoxville.

Most HUD field offices have not maintained the extensive data needed to process these proposals. In our notice to the field issued December 28, 1983, field offices were directed to assemble the comparable data needed to evaluate proposals for retirement service centers, and were given detailed instructions regarding standards of comparability. Field offices are now gathering the necessary information and have been instructed to transmit copies of the data to central office.

Because of the specialized market and limited data, the Department has taken a conservative underwriting approach for these projects. Developers have complained about the 1-year debt service reserve, but we believe it to be a necessary safeguard to the Department, particulary in the early stages of the program. The reserve can be funded by cash or letter of credit and the mortgagee may accept, at his option, a personal note in lieu of cash or letter of credit until final endorsement. If the developer is correct about the market, he will receive his cash, note, or letter of credit back in two years, assuming sustaining occupancy is achieved.

Our responses to specific suggestions made by Mr. Chellis are as follows:

Funding of the debt service reserve in the mortgage.—This would serve only to shift the developer's risk to the Department and would be an advantage to the borrower only if the processing resulted in a 90-percent cost mortgage rather than a mortgage limited by debt service.

Accepting a marketing study as an indicator of demand.—A marketing study and marketing plan are required from sponsors, as outlined in notice H 83-58, because of the Department's limited experience with this kind of facility and our lack of market data. However, we believe other safeguards such as those now required under the program are necessary in addition.

Allowing 100-percent funding of the program [as in 221(d)(3)] and retention of the 1-year debt service reserve.—This is not permitted under the statute. Section 221(d)(4) is limited to a maximum 90-percent loan. A maximum 100-percent loan under section 221(d)(3) is permitted only for nonprofit, public bodies or cooperative mortgagors. Even if we could provide a 100-percent loan, we would not include a debt service reserve for the reason already stated.

Premarketing: Allowing a certain level of rent deposits to evidence demand.—We believe a debt service reserve is a much better form of protection, given HUD's lack of experience in this market. Normal rent deposits, however, are permitted.

Allowing a refundable entrance fee deposit.—The Department's objections to the collection of founder's or entrance fees are based on our past experience. At one time, HUD insured projects which required large cash fees from residents. Several of the projects failed, and the Department was left with the responsibility of housing the residents for the remainder of their lives. We don't want to incur that degree of risk again.

Using income from services in calculating the mortgage.—Our position is that HUD should determine a mortgage amount attributable to shelter only, which reflects an acceptable degree of risk to the Department. We are very concerned about the marketability and reasonableness of cost to the tenant of the nonshelter services. We also believe that the inclusion of income from nonshelter services is not a valid exercise of our authority to insure mortgage on residential property.

Chairman HEINZ. As I said in my opening statement, HUD quite properly has concentrated on asset management in improving the quality of the management of the public housing authorities around the country. And Phil, you have done a really excellent job in doing that. One of the programs that you have had to manage is the congregate housing services program, which Senator Domenici, myself, and others have encouraged HUD to get interested in over the years.

Mr. ABRAMS. You've ordered us to get interested in it.

Chairman HEINZ. Yes. [Laughter.]

We've had to be persistent at times to get HUD interested, and one of the reasons I think HUD has been somewhat resistant is that you are, I suspect, worried that not only will you have to pro-

vide the funds for the housing, but somehow you're going to have to provide the funds for the services. I suspect you look at the $700 million in medicaid and medicare money that Secretary Anthony mentioned as being spent here in Massachusetts. But if you look at the congregate housing services program, it would appear from available information that we really have a very cost-effective program. The Massachusetts experience testified to a moment ago gave some startling low construction numbers, around $20,000 per unit, which as you know is a bit less than the $70,000 per unit that I guess you often quote for Federal housing.

We have findings from a national survey of HUD's congregate housing services program that say that for each $1 spent per congregate housing participant, $3 are saved by preventing or delaying institutionalization, or bringing about deinstitutionalization. Secretary Rowland mentioned that 18 percent of the congregate residents in the OEA study had come from nursing homes.

So my question is this: If you knew that we could make these kinds of savings—I'm not saying you do know that for a fact yet, because you're awaiting your own study—but if you knew that the indicative information I've just described was fact, and that we could really reduce overall costs, would you be willing to go with me and others to the Director of the Office of Management and Budget, David Stockman, to urge him to expand HUD's congregate housing services program? If so, under what circumstances? If not, why not?

Mr. ABRAMS. Well, Senator, I'd love to go and see Mr. Stockman with you. He's a very pleasant man, and we have a very good relationship.

We've discussed that very question within the administration and we've worked closely with the Department of Health and Human Services.

I think we come back again to the issue of who is funding it. You know, the analogy to patients who were taken out of mental hospitals because there was no Federal funding for it, and then put into nursing homes because there was Federal funding for it is an interesting analogy.

Now, the perception that the coordination between the agencies isn't what it should be, I think is accurate. And I think our efforts to try and make the housing managers more aware of the HHS services and your efforts under the Older Americans Act, to get the agencies on the aging to concentrate on training their people so that they can provide access to the programs is on the right track.

Our preliminary conclusions in the congregate services demonstration is that it is certainly, as I said in my testimony, less expensive to keep frail elderly people living independently. And not only that, they're much happier living independently than being institutionalized. So it's the best of all worlds. The question is how do you coordinate HUD and HHS so that the $800 million provided under the Older Americans Act can be utilized under housing programs, either HUD or Farmers Home, or State and local housing programs.

I wouldn't hesitate to go with you to see Mr. Stockman and suggest that some portion of that $800 million be directed toward the housing programs and the frail elderly who need services and eld-

erly housing, if there was some way to do that without hamstringing the States who administer the funds.

Because when you come down to the final analysis, the decisions on where those funds go and how much of the $800 million is provided for congregate services and elderly housing, it becomes a State and local decision.

If more direction is needed, rather than more latitude, then perhaps that's appropriate. But I'm not expert enough to make that judgment.

Chairman HEINZ. We seem to be in the Reagan administration at some kind of an impasse where an impasse doesn't make sense.

The Reagan administration is, above all, particularly where domestic programs are concerned, dedicated to better use of existing resources. More use of existing resources. More efficiency. And yet we have not found a mechanism to coordinate the missions of two departments—not any large number of departments, just two—it's not like the Defense Department where you've got the Army, Navy, the Air Force and the Marines plus the Joint Chiefs who are doing their own thing. We're talking about two fairly understandable agencies, complicated, but understandable. We should be able to find such a mechanism. Perhaps we need a very small interagency task force working together with the representatives of the National Governors' Association, maybe a mini-"New Federalism" kind of approach just aiming at this very specific problem.

Unfortunately, we're probably going to play administrative ping-pong with HHS saying, "Well, we're not responsible for housing," and HUD saying, "We can't really do much about medicare and medicaid." Meanwhile, Dave Stockman is saying, "That's up to the States," but not approving any waivers, as he is saying to us in the Finance Committee, "Well, we're not going to grant any more waivers for social HMO's because they might cost more, because they can't be demonstrated not to cost more. And we cannot support the Health Care Coordination Act until we have the results of those social HMO waiver programs." What we seem to be getting into is a house of cards. When we construct it, it keeps falling down on us, and we never seem to quite build something that lasts.

Have you got any ideas how we can get out of this circularity that we seem to have built ourselves into?

Mr. ABRAMS. Well, the vehicle within the administration for getting these issues brought to a conclusion is the Cabinet Council on Human Resources, on which we at HUD and the Department of Health and Human Services, as well as others, participate. And this whole issue has been discussed and is continuing to be a subject of discussion at that Cabinet Council, and maybe the hearing today will stimulate that Cabinet Council to come to some conclusions in coordinating it.

But the principal reliance again is on State government to make the allocation of those resources that they get under the Older Americans Act and those block grants available where they're needed to provide the congregate services.

I suppose we could debate about whether $800 million is enough, but that's really a different subject than debating whether or not the facilities are there for providing congregate services.

Chairman HEINZ. Thank you, Phil. Secretary Rowland?

Mr. ROWLAND. Phil talked about the Older Americans Act as the source of money for some of these programs we've been talking about. I don't see the Older Americans Act as the source of money. The Older Americans Act is very, very small in terms of total dollars.

I think we've got to look toward the two large programs: medicaid and medicare, and divert money from institutions to community care. And if we do that, if we can save money in institutions, we can then justify putting it in the community, increasing people's independence, and improving their lifestyle.

But the small amount of moneys nationally that are in the Older Americans Act really don't meet the problems of chronic health care for our elderly citizens.

Chairman HEINZ. I think there is absolutely no doubt about that, Secretary Rowland. You are quite right that we should keep our eye on the apple and the apple is not the Older Americans Act, at several hundred millions of dollars a year, but the medicare and medicaid programs, which spend tens and tens of billions of dollars a year.

I thank you, Amy Anthony, Dick Rowland, and Phil Abrams. You've been an illustrative panel of witnesses. I am also indebted to Mayor Flynn for having participated both this morning and on your panel. Thank you all very much for your testimony and being here today.

Our next panel consists of Ray Struyk and Ellen Feingold.

Let me just note that this is an anniversary for Ms. Feingold, the second anniversary of her appearing before the Aging Committee, exactly 2 years ago.

Happy anniversary.

STATEMENT OF ELLEN FEINGOLD, EXECUTIVE VICE PRESIDENT, JEWISH COMMUNITY HOUSING FOR THE ELDERLY, BRIGHTON, MA

Ms. FEINGOLD. Thank you, Mr. Chairman. I am delighted to be here today. I am Ellen Feingold, executive vice president of Jewish Community Housing for the Elderly in Brighton. I also represent the Citizens Housing and Planning Association of Metropolitan Boston, the New England Elderly Housing Association, and the National Low Income Housing Coalition.

I have given you a rather long statement for the record and I will try to touch on the important points of it here. I want to thank you for coming to Boston. Massachusetts has traditionally had a very long interest in housing. We have a State public housing program that dates from before World War II, and a veterans and elderly housing program that date from the late 1940's and early 1950's.

Our impetus comes from being an old urban State where our housing supply is old and has not in fact kept pace with the growth and the needs of the population. The State has taken a vigorous role in trying to meet those needs.

You've asked me to talk about aging in place and its impact on federally assisted housing. I had the impression I was to be the

color commentator, to tell you about how it is in the housing that we manage.

Jewish Community Housing for the Elderly is one of the largest owners and managers of nonprofit sponsored elderly housing in the country. We have 4 buildings ranging in age from 5 to 13 years old, with close to 1,200 tenants in 834 apartments, almost all of whom are subsidized under section 8.

Our tenants' average age is 79 with a couple of tenants over 100 years old. Almost 40 percent of the original residents of our oldest building, that's 13 years old, are still living there, most of them in their eighties. That's what I call aging in place.

At its best, aging in place means that a person is able to grow old in his or her own home among people and places and possessions which mean stability and comfort and security. It means that the environment is able to continue to provide the things which are needed, even as those needs change. Now, what are the needs that change, and why are we trying to make a distinction between people who age in place and need services, and people who need to leave and get nursing care?

In our housing it's people who begin to have trouble carrying their groceries or getting to the supermarket, or reading their medicine labels, maybe even remembering if they took their medicine this morning. Maybe they're afraid of the changes in the neighborhood.

None of these things require nursing care. You are also asking questions about comparative costs. Whatever the services that are necessary to deal with these kinds of problems, their costs are nothing compared to the costs of putting people in institutions.

These are all aspects of normal aging. We will probably all experience them. And the services that we have in places like Jewish Community Housing really do go a long way to meeting these problems.

Why, then, does the phrase aging in place have a negative connotation in terms of Federal policy? I was delighted to hear some of the things that Under Secretary Abrams said because Federal housing policy, not just of this administration, but traditionally, has been to consider elderly people as being of two kinds: Those who are independent, and those who need nursing services. This just plain isn't true, and we need to overtly change our housing policy to acknowledge that.

The 202 program itself includes language that no facilities for medical care should be included in a 202 project for elderly residents.

At Jewish Community Housing, we have changed our definition of "independent elderly" to reflect more accurately the reality of what we do every day. We say that independent elderly are persons who are either able to care for themselves, or who recognize their need for care and are able to organize such care for themselves.

We believe that independence means to be in control of one's own life and to have access to choices and services that make it possible.

To do this, we have on staff two full and one half-time person whose sole functions are the organization of the delivery of services. We also have an extremely close relationship with at least one

Jewish community service provider, namely the Jewish Family and Children's Service, which provides a wide range of reimbursed services, of paid for services, and donated services in our buildings.

It's this kind of a package that makes it possible for people to stay as long as they can. We strongly believe that the single most destructive thing that can happen to an older person is to be moved to a new living place unnecessarily.

We question the current vogue for elder facilities which feature moving people as they age from a house to an apartment, to a congregate facility, to a nursing home. It may sound good; it sounds very reassuring. There's always a place that will take care of you.

But it has the effect of demoting people from one level to the next, and can seriously disrupt a person's efforts to remain independent and in control. We very much prefer to keep people in place and move services.

From our experience, then, we've developed a series of recommendations. The first several are, one, that Federal housing policy should explicitly acknowledge that people should be able to age in place; second, that housing laws and regulations should require and support service coordination by housing authorities and sponsors of elderly housing; third, that flexibility and local variation should be supported and encouraged; and, fourth, that in addition to providing and requiring service coordination, housing managers who want to provide services themselves should be authorized and funded through their HUD supported budgets to do so.

I was very glad that you asked Under Secretary Abrams to talk about the problems of interagency coordination; they are very real. A Federal agency comes before its congressional authorizing committee and defends its budget. Nevertheless, for those of us who are the paying public, and for those of us who are the service requiring public, if this way of doing it saves Federal dollars, then I think the HUD budget should be increased to save overall Federal dollars.

If there are better ways of paying for needed services, fine. Appropriate the money somewhere else, from someplace else. But I don't think that's a saving. I think that is a fiction which comes out of the competition among agencies for budgets.

We also believe that unlike family housing, elderly projects benefit from being larger. There currently is a policy in effect which we agree with that it was a mistake to build huge public family housing projects.

But that policy should not be applied across the board to elderly housing projects. Larger administrative budgets, like Jewish Community Housing's, can afford service coordination, just because the administrative budget becomes large enough to support a staff person. Services themselves can be clustered and administered more efficiently. There are more people in the community to support one another. And a variety of needs can be met more effectively.

So our fifth recommendation is to encourage and support larger elderly housing developments where the local market will support them and to reverse HUD's current limitation of 75 on the number of units size for section 202 housing.

It's also important to note that not only the residents are aging. So are the buildings. We also want to recommend to you a new program to support major repairs, energy retrofitting, security changes, and some very important remodeling, which needs to take place in order to support the services and facilities to serve this older and frailer population.

One last point: Let me go back for a moment to Jewish Community Housing's definition of independent elderly. Someone who can take care of him or herself, or organize his or her care using family and community resources. One outcome of this policy is the recognition that physically frail or disabled people are far more independent than those who are mentally disabled.

We have some residents who are almost completely bedridden, but they run their own lives, and are good tenants, utilizing the telephone, their families, and community organizations. This is unfortunately not so for the mentally disabled. Even physically well, these people are not independent, and require an enormous amount of management attention and social service intervention.

Yet, a nursing home is not the right place for them either. So another of our recommendations is that in addition to the training program which you are recommending, which we strongly support, that you put into your package a set of demonstrations that will lead to an understanding of what are the best ways, and I say ways because there's never only one, to house the physically well but mentally disabled elderly.

It's very hard to put into 5 minutes all of the things that I'd like to leave with you. I think I would like to conclude by saying that it's important to note that assisted housing really works.

We're here testifying about the things that we would like to make it better, but it really works. The linking of decent, safe and sanitary housing with Federal rent supports under section 8 puts elderly residents in buildings like ours in a position where no matter how poor they may be, they do have cash left for their food and their clothing and their other expenses, after paying for shelter. This in itself is a very important aspect of independent living, and it must not be forgotten as we discuss the changes that are needed.

When we add the service package and the coordination needed to make the services function effectively, we will have developed for this country a first rate elderly housing policy.

I want to thank you again.

Chairman HEINZ. Ms. Feingold, thank you very much for excellent testimony. As with our other witnesses, your complete prepared statement will be made part of the record at this point.

[The prepared statement of Ms. Feingold follows:]

PREPARED STATEMENT OF ELLEN FEINGOLD

My name is Ellen Feingold, and I am executive vice president of Jewish Community Housing for the Elderly of Brighton Mass.

Senator Heinz, members of the committee, thank you for the opportunity to appear before you today in behalf of the Citizens Housing and Planning Association of Metropolitan Boston, the New England Elderly Housing Association, and the National Low Income Housing Coalition.

You asked me here today to testify on the "aging in place" phenomenon and its impact on federally assisted housing. I will describe for you what happens in the

real world as people living in publicly supported housing age—the reality of the years between complete independence, and the need for medically oriented care provided in a nursing home. I will describe for you the ways in which subsidized housing, supported with a flexible range of services, can sustain independence and provide the most sensible, dignified, humane, and least costly home to most older people.

First, let me describe Jewish Community Housing for the Elderly. We are a nonprofit developer and manager of four buildings in the Boston area, ranging from 5 to 13 years old. They were built under four different State and Federal programs, with 834 units, and close to 1,200 tenants, about 95 percent of whom are very low income tenants subsidized under section 8.

JCHE was founded in the late 1960's in response to the growing shortage of housing in the Greater Boston area which was having an especially destructive impact on the lives of the elderly. By 1969, the organization realized that the only real solution to the housing crisis was to begin to build desperately needed housing units, utilizing the various State and Federal housing tools which had been enacted for this purpose.

JCHE includes on its board of directors some of the foremost developers, lawyers, accountants, and builders, as well as social and community workers in the Boston area. They have joined together in an effort to do something of vital importance for their community. Thousands of hours of valuable time, energy, and skill were poured into JCHE's projects which have become models throughout the country.

Ultimately, four large buildings were erected.

	Ulin House	Leventhal House	Genesis House	Golda Meir House	Total
Financing program	202	236	MHFA	202	.....
Date occupied	1,971	1,973	1,978	1,979	.....
Number of units	243	256	211	124	834
Efficiencies	171	58	.....	.....	229
1 bedroom	72	198	196	119	229
2 bedroom			21	5	26
Handicapped			22	11	33

The minimum age of entry into an elderly housing development is 62. The average age in my development is 79, with a range of from 55 to 102 (the 55-year-old is the spouse of an over-62-year-old). Clearly, we are doing some thing right. Thirty-nine percent of the original tenants of Ulin House, opened in 1971, are still living there—most in their eighties.

When our residents first came to live in JCHE, they were fully independent. But what happens as you age?

First, it may become difficult to carry your groceries. It may even be difficult to read the labels in the supermarket, let alone the prices. Perhaps you can't even get to the store. Does this mean you need a nursing home with medically oriented 24-hour-a-day care?

Later, it may become difficult to keep your apartment clean, perhaps even minimally clean so that health and safety is not endangered. Is this the time to go to a nursing home?

Perhaps you find your heart and breathing limitations make you increasingly reluctant to go out of your apartment very much. Now do you need a nursing home?

If you are having trouble reading the labels on your medications, or remembering which to take when, do you need a nursing home?

Maybe your neighborhood is a little rougher than is confortable. Perhaps you are afraid of being robbed, even mugged. Is this a proper reason to move to a nursing home?

Obviously the answer to all of these questions is no, the elderly person who is experiencing all of these changes does not need nursing care. All of these changes can and are experienced by elders living in their own homes or in conventional and market housing as well as in assisted housing.

These are not unusual occurances. They are the very ordinary "aging in place" phenomena which have come to have such a negative connotation. What does "aging in place" really mean? At its best, it means that a person is able to grow old

in his or her own home, among people and places and possessions which mean stability and comfort and security. It means that the environment can continue to provide the things which are needed, even as those needs change.

Most of us are aging in place every day—I have put away my tennis racket for good, and have stopped taking modern dance classes. I have even moved around some of the things in my kitchen in recognition of the fact I no longer have a houseful of teenagers for whom I used to keep a very full pantry.

Why, then, do we use the phrase with alarm when talking about publicly assisted housing for the elderly? Only because Federal housing policy has not, in fact, recognized the need for an environment that is sufficiently flexible to provide for the changing needs of the residents of elderly housing. The section 202 program, for example, includes specific language targeting its units to the independent elderly, and prohibiting medical facilities for those residents who are not the healthy, vigorous persons envisioned in the statute. These latter should move out, move on. Here, in federally supported housing designed specifically FOR the elderly, there are to be no facilities to support normal aging processes. Fortunately, administrators at every level have increasingly ignored or worked around these restrictions.

At JCHE, we have revised our definition of the independent elderly whom we serve to more accurately reflect our concept of mission:

—We define independent elderly as persons who are either able to care for themselves, or who recognize their need for care and are able to organize such care for themselves.

—We provide housing and housing-related services and facilities which support the ability of independent elderly persons to care for themselves.

—We assist current residents with the organization of their care and support services from family, friends, and social service agencies to meet their increasing needs as they age. We try to accomodate the needs of current residents as long as this does not interfere unduly with the lives of other residents, the maintenance of the building, or pose a risk to health and safety of the tenant or others.

—We do not ordinarily accept new residents who require major supports at entry.

Independence, in many cases, means to be in control over one's life, and to have access to choices. As we grow old, our ability to be in control dimishes, and so do our choices. To support and enhance independence, it is important that a range of services and facilities needed by elderly persons be made available and accessible. No one solution is right for all elderly.

We believe the time has come for the Federal Government to eliminate inappropriate restrictions, to face up to the needs of real-world elderly, and to make the most effective, constructive, humane and cost-conscious use of Federal resources in housing our elders.

RECOMMENDATION NO. 1

Recommendation No. 1 is to amend Federal housing policy to acknowlege the phenomenon of aging in place, and to allow and encourage a variety of arrangements which make it possible for one to grow old safely and comfortably in one's own federally assisted home.

We also believe that one of the single most destructive things that can happen to an older person is to be moved to a new living place unnecessarily. The current vogue for facilities which include distinct "levels of care" ranging from houses through apartments and congregate facilities to nursing facilities can, in fact, have the effect of "demoting" people from one level to the next as the administrator's assessment dictates. The individuals moved for these reasons are frequently made worse by the move. Their orientation is disrupted and there is a very real trauma in the effort of relocating, especially when this signifies an irreversible worsening of housing independence. The loss of privacy and control over one's life that is part and parcel of a skilled nursing environment is not conducive to maintaining the highest level of independent functioning possible. In many cases, the move is really only a matter of administrative convenience, not cost or service effectiveness, let alone what is best for the individual.

We very much prefer the concept of keeping people in place, and moving the appropriate service components around as needed. This is easily possible in an elderly development with its concentration of clients and services, and becomes one of the most successful ways of helping elderly persons to remain independent, to remain in control of their own lives.

RECOMMENDATION NO. 2

Recommendation No. 2 is, therefore, to amend Federal housing statutes and regulations to require and support, as a necessary and appropriate administrative cost, service coordination for residents of elderly housing.

Every housing authority and every development over a minimum size (say 35 units) should be required to provide service coordination for its elderly tenants, just as it is required to provide maintenance services and periodic rent recertification as part of its management budget. Funds for this can be earmarked from HUD, or from HHS, or from AoA, but they must be identified and restricted for service coordination purposes. All housing managers know how the physical demands of the building tend to swallow up all resources—when the plumbing backs up into the basement, it most assuredly gets everyone's attention right away. Staff resources intended for service coordination must be both an integral part of housing management but kept separate and distinct so as not to be obliterated by other demands.

RECOMMENDATION NO. 3

Recommendation No. 3 is for program flexibility, including legislative and regulatory changes to make possible the construction of community facilities and so-called commercial space within elderly housing programs if this will enhance the ability of residents to remain independent longer.

The elderly population is no more uniform or homogeneous than any other segment of the population, and its housing and service needs are also as locally variable as in the vast variety of localities in these United States. Key to many of our recommendations today is that there is no one right way. Federal programs will be most efficiently utilized if they allow easily for local variation.

One housing development may find that converting an underutilized crafts room into an exercise and preventive health facility staffed by a local hospital is a highly effective and well-utilized means of encouraging health in its residents. Another development may reject any medically-related services on premises.

One development may have a mandatory meals program, another a title III-C lunch site, and a third may have no onsite food assistance. At JCHE, we are finding that the most effective way to support the nutritional needs of the close to 900 residents in our three interconnected Brighton buildings is an onsite convenience store into which we are now building a delicatessen counter which will serve prepared foods such as soups, cooked meats, salads and stews for those who find food preparation too difficult. In our case, we are paying for this renovation with donated funds, but if the store is as successful as we anticipate, we would recommend that the construction of such facilities not be excluded from federally assisted housing under the rubric of commercial space because of the important role they play in making food service accessible.

In a comprehensive study we did 2 years ago of the food meals and preferences of our residents, we learned that comparatively few of the 900 people living in the Brighton complex wanted a meals program, and, more important, that very few of the people who were judged to have serious problems in feeding themselves were among those who said they would use a meals program. It seemed that people who had real trouble marketing and cooking were also too frail to participate comfortably in a congregate meals program.

It is our hope that making foods, both prepared and needing preparation, easily available will assist a substantial number of our residents to remain independent longer.

Flexibility should even extend to those housing providers who wish to provide services a well, JCHE, for example, prefers to concentrate its resources on being a good houser, providing service coordination through its administrative operations. JCHE is large enough so that our administrative budget can, indeed, cover the cost of two and one-half staff persons coordinating service delivery and we have a very close relationship with Jewish Family and Children's Service which provides the major share of donated, paid for, and reimbursed services in our bulidings. However, other organizations may prefer to provide those needed services themselves. Neither HUD nor HHS programs should be structured to preclude any of these arrangements.

RECOMMENDATION NO. 4

Recommendation No. 4 is to amend Federal housing statutes and regulations to permit housing authorities and sponsors to include the provision of services in their

administrative budgets as well as service coordination if this appears to be the most effective and efficient way to deliver these services.

It should be noted that one consequence of a Federal housing policy based on the assumption that all residents are strong and well is that service delivery is poor, inefficient, not well targeted, and sometimes inappropriate. There are gaps, there are unintentional inequities, there are duplications. Yes, it is probably not HUD's money which is being misspent. But from the point of view of both the paying public and the service-needing public, it is foolish not to require those Federal agencies assisting the elderly to cooperate with one another to maximize the effectiveness of money spent, and to minimize the duplicative, counterproductive and less effective use of these funds. Our recommendations for agency program flexibility coupled with service coordinators attached to housing should go a long way to remedying this.

Perhaps this is a good point to outline in a little more detail the services which JCHE residents use and to which we attribute our success in helping residents to remain in their own homes as long as possible. First, as I mentioned above, JCHE maintains a staff of two full-time and one half-time person entirely dedicated to resident services and service coordination. Frankly, I cannot imagine what our housing would be like without these people. They are as essential to the functioning of our buildings as the administrative, maintenance, and cleaning staffs. We, like virtually all elderly housing, maintain a 24-hour-a-day emergency call system. We have a convenience store. We have a number of community spaces of varying sizes for meetings, parties, concerts, card playing, and just lounging around.

But even more important are the wide range of services which our residents receive through a variety of service providers in our area. Unfortunately, I have not been able to get firm figures on all these services at this time as the local area agency on aging is in the process of computerizing, and at this moment can't provide the statistics either manually or from the computer.

However, many of our residents' services come through the Jewish Family and Children's Service which tells us that 300 of our residents in the Brighton complex are currently receiving homemaking services. Many of our residents are also served by Visiting Nurses and home health aides. In addition, at this moment, 60 of our residents are receiving social services from JF&CS and 2 to 300 residents make some use of these services annually. The kinds of social services provided include individual, marital and family counselling, information and referral, advocacy and coordinating services with other agencies, and case management.

We have calculated that we would need the services of six full-time social workers to provide the same level of social services, supervision and administration. We are convinced that if we did this ourselves, it would cost more and would provide us with less quality by reducing the range of skills now available to us through the specialized agency. It would also confuse both residents and social workers as to who the client is. Nevertheless, while this is our strongly held opinion with regard to our organization, it is clearly an issue where we continue to recommend flexibility.

It should be noted that JCHE, with 834 units, is able to include two and one-half staff positions within our HUD-approved administrative budget. Scale is a very real issue here. Over the years, housing specialists have stressed the importance of reducing the size of the vast public housing developments of the past, observing that these rapidly became ghettoes of the poor, disadvantaged and minority.

However, with respect to elderly housing, this does not hold. Many observers believe that larger elderly projects generally work better than smaller because they make it possible to concentrate and cluster more services and a greater variety in one area as well as other economies of scale. They also lead to more variety and diversity within the residents themselves, and allow for groups of residents with common interests where smaller projects may have only one or two people interested in a particular activity. This leads to greater variety of communal activities which do so much to enhance the ability of elders to avoid isolation and to remain independent longer.

RECOMMENDATION NO. 5

Recommendation No. 5 is to encourage larger elderly housing developments wherever local markets will support this, and to remove the current ceiling of 75 on the number of units in a section 202 development.

What, then, does our own service coordination staff do? Each year, we work with some 180 to 200 residents, solving immediate social problems or working with families and making referrals. This work includes mediating disputes with neighbors, and serious marital blowups.

Among our residents are 20 couples or other two-person households where one person is caring for a severely ill or frail second person. These latter would surely be in a nursing home without their spouse, sibling or friend to care for them. However, the caregivers need support, and advice, and assistance in getting services for their charge.

Last year, 45 people died and 33 others left for nursing homes from our buildings. Almost all of these were heavy users of services before they left. It is certain that without these services, many of those who died would have had to spend some of their final year in a nursing home, and those who ultimately did go to such a facility would have 6 months to a year longer there. This year, we know of 20 to 35 residents who are being maintained through a combination of social, community, family, and neighbor services who would otherwise be in a nursing home.

One of our two full-time resident services staff works almost full time organizing, coordinating, and supervising the work of resident volunteers. Here, I am talking about over 200 of our residents who cary out vital functions within our buildings, staffing the security desks at four buildings, answering all incoming telephones, doing some secretarial work, and carrying home-delivered meals to their neighbors who are shutins. It should be clear that this service coordination has two major functions: obviously it provides vital services to the community. But more important, it provides a way that our residents can use their time productively, can feel a sense of value and importance and contribution to the life of their community, and thus maintain their own sense of control and independence more effectively. If I help you today, then it is more likely that someone will help me tomorrow.

In addition to these 200 residents volunteering within our housing, another 100 volunteer in other community organizations, and our staff person plays a crucial role in developing and organizing these opportunities, in making the arrangements that facilitate some of them, in doing the paperwork for others. Make no mistake about it, it takes a staff person to make this level of volunteer activity a reality.

Let me go back to the JCHE definition of independent elderly—someone who can take care of him or herself or can organize his or her care using family and community resources. One outcome of this policy is the recognition that physically frail or disabled people are far more independent that those who are mentally disabled. And, in fact, with a service package available, this is true. We have residents who are virtually bedridden, but who are in complete control of their own lives because they are able to manage, by telephone, to organize friends, neighbors, family, and caregivers to do for them what needs to be done. Why shouldn't they continue to live with us? If they lived in their own houses, or in private apartments, no one would dream of requiring that they move. They are welcome under our policy to remain at JCHE. We find, indeed, that when their condition deteriorates so severely that the services which they have assembled are really no longer sufficient, they are willing to recognize this, and are able to face up to the need to move on to a nursing facility. They may not be happy about this, but they acknowledge its necessity, thereby retaining decisionmaking control over their lives.

On the other hand, every facility like ours finds itself over-burdened and often seriously disrupted by what may be a tiny number of physically well but mentally disturbed or disoriented residents. Our definition of independent elderly helps us to understand this. These people, sadly, can be a real danger to themselves and to other residents, and often are not able to care for themselves adequately. They require an enormous amount of management attention. Services, short of round-the-clock monitoring, do little in this situation. Yet a nursing home is not the appropriate place for such persons, either.

RECOMMENDATION NO. 6

Recommendation No. 6 is that HUD should support a number of demonstrations of the best ways to house the physically well but mentally disabled elderly.

However, this does not solve the problem now for those of us who house these people. The physically well but mentally ill constitute the most difficult problem for housing managers and require a disproportionate share of both outside services and management intervention. We have about 10 people living in our buildings who are major, serious, frightening and sometimes destructive intrusions into the lives of their neighbors and the physical integrity of the buildings. There is no place else for them to go—when they have been hospitalized, they sooner or later return home, their condition being judged by the hospital as no longer dangerous to themselves or others.

Other mental problems requiring management attention and social services include:

—Some 15 residents with symptoms of hallucinations, paranoia, severe depression, or mania who have a history of intermittent hospitalization.
—Another 10 to 15 residents we know of with clinically diagnosed physically caused deterioration, usually post-stroke or Alzheimer's.
—Some 30 to 40 people with observable memory loss causing management problems such as frequent loss of keys or apartment lockouts, pots left burning on stoves, water left running in sinks and tubs causing apartment flooding, forgotten rent payments, and loss of orientation in the buildings or in the neighborhood; and
—A few serious public alcoholics requiring management or even police intervention.

It is obvious that services are absolutely essential for the sake of both the individuals involved and the housing developments to handle problems of these kinds.

As noted at the outset, it is not only the people who are aging—so are the buildings.

RECOMMENDATION NO. 7

Recommendation No. 7 is to enact a program authorization for elderly housing like the flexible subsidy or modernization programs to do major repairs, energy retrofitting, security changes, and the important renovations that are needed in order to house an older and frailer population.

These buildings constitute an immense public investment. In most cases, they have appreciated along with the local real estate market. It is pennywise and pound foolish not to invest in the major maintenance and modernization of these buildings, a strategy the private sector would only tolerate as a prelude to disinvestment. The savings in energy consumption and unnecessary nursing home placements makes such a recommendation even more compelling.

Parenthetically, I'd like to mention here that no more efficiency apartments should be built for the elderly. They save very little money over one-bedroom units of the same scale and quality, and they have been proven to be far less satisfactory in terms of supporting those who are aging in place. Where can your grandchild sleep in an efficiency if you need a few nights' care when you have just returned from the hospital? Where is there room to stash some of the apparatus which people begin to need as their physical capabilities age?

Two years ago, as JCHE was preparing to build its fifth building, we compared what happened to people living in efficiencies and one-bedrooms at the end of their tenure at JCHE. The hard fact is that almost everyone who leaves JCHE either goes to a nursing home or dies. For purposes of this study, we ignored the 10 percent who move to other housing. Of the remaining 90 percent, 58 percent of those living in efficiencies left to go to nursing homes while 42 percent died in their homes. Almost the opposite was true of those living in one-bedrooms, of whom 35 percent went to nursing homes and 65 percent died. We believe the conclusion is inescapable that one-bedroom apartments make it possible to sustain independent living much longer, in many cases until the end of life, while efficiencies become unusable for those who are growing increasingly frail.

One thing needs to be said in conclusion: assisted housing works. The goal of providing decent, safe, and sanitary housing to those who cannot afford it in the marketplace remains valid, 35 years after its enunciation by Senator Robert Taft, Mr. Conservative. The more recent standard that thsoe needing housing assistance should not be required to pay more than a specified portion of their adjusted income for shelder costs—27 percent this year—also works. While I would like to see this figure returned to 25 percent (closer to the 17 to 20 percent which most nonpoor people spend), it is striking to see how our residents, poor though many of them are, and a substantial number live on SSI alone, have cash for food and other necessities after paying their rent. That elders should be able to count on having cash after paying for shelter is a standard that any civilized society should be able to live up to. Elders living in publicly assisted housing have a good chance at it.

When we formalize in housing policy our acknowledgement of the right to live in housing, assisted by a coordinated service package, until more medically oriented care is needed, then we will have completed the policy basis for a sound elderly housing program.

Chairman HEINZ. You have done in 5 minutes what most people would have taken 55 minutes to do. And, by the way, you have done a very good job of giving us what you might say is a little not only local color, but program color to color in what has up to now

been a sketch, really, of the situation. You've done it extremely well. We're grateful to you.

Our second witness is Dr. Raymond Struyk. Ray is a senior analyst at the Urban Institute and is going to give us some policy ideas for further study. Ray, please proceed.

STATEMENT OF RAYMOND J. STRUYK, PH.D., SENIOR RESEARCH ASSOCIATE, THE URBAN INSTITUTE, WASHINGTON, DC

Dr. STRUYK. Thank you, sir.

The theme of my testimony is that meeting the housing needs of elderly Americans requires that these needs be broadly defined and that public aid, where appropriate, be cast in the context of the dual requirements of adequate shelter and supportive services essential for living a full life in the community.

In short, housing assistance for the elderly cannot be viewed in isolation from long-term care assistance in particular, or from other related requirements for living as independently as possible.

To be sure, the struggle to insure that all elderly Americans live in decent and affordable housing has not been won. But the problem is even more serious for those frail elderly who are burdened with both the traditional housing problems, and an inability to use their homes.

Two reasons are foremost in shifting our attention to this group: First, the need to aid these households efficiently at a cost less than that associated with institutionalized services; second, the sharply rising number of elderly that can be expected to be in this frail group in the years ahead as longevity increases.

Today, about 4 million elderly headed households experience one of the two traditionally defined housing problems, of living in a deficient unit or spending an unacceptably high share of income on housing. A majority of these households have incomes below the poverty line.

Of those having one of what might be termed a dwelling specific problem, between a quarter of a million and 800,000 also have a member who has a functional limitation that requires supportive services that are not now being met through informal care. These households, who are not now living in assisted housing, are the target group for this discussion.

In considering how to deal with the needs of this group, it is essential to remember that the elderly cannot be viewed as a monolithic group. In addition to having widely differing housing related problems, they differ in ways that strongly effect the appropriate type of aid to provide.

Most important among these distinctions are whether they are homeowners or renters, their ability to pay for services, and the extent of their unmet need for supportive services.

For the balance of this statement, I will concentrate on low-income elderly who have housing specific problems as well as difficulty in using their homes because of physical impairments.

Two approaches appear to be particularly worthy of consideration: One is what I call an independent living voucher program. The voucher would entitle the frail elderly person or couple to occupy a rental unit in a congregate housing facility, a housing

project providing independent living with the necessary nonmedical support services.

The projects would be privately developed, owned and operated. Units in them would be available for voucher holders as well as those elderly who could afford to live there without assistance.

It would appear that the housing voucher demonstration now being implemented by HUD could be modified simply to accommodate this approach.

The second approach is aimed at homeowners. In this case, a housing voucher would complement the provision of services under medicaid in those States that have taken advantage of the waiver which permits provision of supportive services at home rather than in an institution.

Evidence from the Experimental Housing Allowance Program shows that such assistance is effective in maintaining dwelling quality and eliminating excessive housing expenditures.

Combining the use of a housing voucher for homeowners with the requirement that households be receiving substantial supportive services under medicaid would sharply concentrate these housing assistance resources on those with the greatest need.

Meeting the housing-related needs of the elderly is complex and challenging, both because of the diversity of the needs themselves, and because of the way in which provision of housing assistance and aid for supportive services has been organized. The Special Committee on Aging is in a unique position to rise above the jurisdictional issues which we've heard so much about, to formulate an overall strategy for dealing with these problems. Thank you.

[The prepared statement of Dr. Struyk follows:]

HOUSING-RELATED NEEDS OF ELDERLY AMERICANS AND POSSIBLE FEDERAL RESPONSES

by

RAYMOND J. STRUYK

Testimony Presented at Hearings of the
Senate Special Committee on Aging

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The central theme of this testimony is that meeting the housing needs of the elderly requires that these needs be broadly defined and that public aid, where appropriate, be cast in the context of the dual requirements of adequate shelter and the supportive services essential for living a full life in the community. In short, housing assistance for the elderly cannot be viewed in isolation from long-term care assistance in particular or from other, related requirements for living as active and independent a life as is reasonable.

This theme derives from the recognition that there is more to an adequate living environment than a good quality, affordable dwelling and that there is more to long-term care than a bed in an institution. Assistance to the elderly needing help to fully use their homes will reduce the role of institutionalization. Cost-effective assistance to help many of the elderly remain in the community can only be provided if assistance for housing and support services is jointly provided, thus replacing the separate provision of these services that characterizes the system of aid now in place.

The balance of this statement proceeds in two parts. I begin with a general inventory of the housing problems of the elderly, considering dwelling-specific items as well as needs for supportive services. The second part outlines the way in which public policy might be organized. These topics -- housing problems and a policy framework -- are those which I was asked to address by the Committee.

Before going further it is important to make two points about the attributes of the elderly that fundamentally affect the way in which one thinks about assistance for them. First, as people reach retirement age

and beyond, they experience numerous changes, sometimes in rapid succession: incomes fall from pre-retirement levels, children leave home, health problems and activity limitations emerge, a spouse must be institutionalized or dies. These dynamics mean that public policy to help with housing problems must be very flexibly designed -- ranging from rent supplements, to counseling homeowners about various housing options, to provision of support services to compensate for the inability to perform key activities of daily living.

Second, the elderly cannot be viewed as a monolithic group. As just suggested, they have widely differing housing-related problems. At least as important, they differ among themselves in three fundamental ways that must be taken into account in designing public policy: health status (including activity limitations), economic resources, and whether they are homeowners or renters. Again, the resultant emphasis is for policies to be flexible enough to accommodate the elderly in these various circumstances.

Housing and Housing-related Needs

In considering the housing needs of the elderly it is useful to make the distinction between the traditional "housing problems" and the needs which arise from health problems and activity limitations. The housing problems (called dwelling-specific problems hereafter) include deficiencies to the dwelling, spending an excessive share of income on housing, and living in over-crowded conditions. These are problems which can be measured in fairly straightforward ways and whose definition does not generally have a special dimension for the elderly.

Housing problems associated with activity limitations -- hereafter called dwelling-use problems -- are much less precisely defined. Indeed, activity limitations, used here as a shorthand label for the larger set of health-related problems, are better thought of as an indicator of a potential housing problem. Limitations on the activities of the elderly can mean that they are unable to fully utilize the dwelling -- unable to use the kitchen and bathroom without assistance (possibly because they are inconveniently located in relation to living and sleeping areas), unable to properly clean and maintain their home, unable to go shopping without help. On the other hand, these limitations may be effectively offset by the assistance provided by other family members or neighbors or by modifications to the dwelling itself. Unfortunately, the only general measures of housing needs arising from activity limitations focus on the limitations themselves, not on the services the household must do without because of them.

Thus, in trying to assemble counts of the number of elderly with housing-related problems, one must combine reasonably "hard" estimates of the traditional dwelling-specific problems with less direct, "softer" estimates of dwelling-use problems. As depicted in Figure 1, the apparent needs for support services are sharply reduced by the assistance (intervention) of family and friends. Also difficult -- this time because of data limitations -- is calculating the joint occurrence of dwelling-specific and supportive service needs.

Dwelling-specific needs. Our focus here is on the incidence of physical deficiencies and excessive housing expenditure burdens in 1979. (See Table 1 for figures; definitions of these needs are consistent with

FIGURE 1

SOURCES OF HOUSING-RELATED NEEDS FOR THE ELDERLY

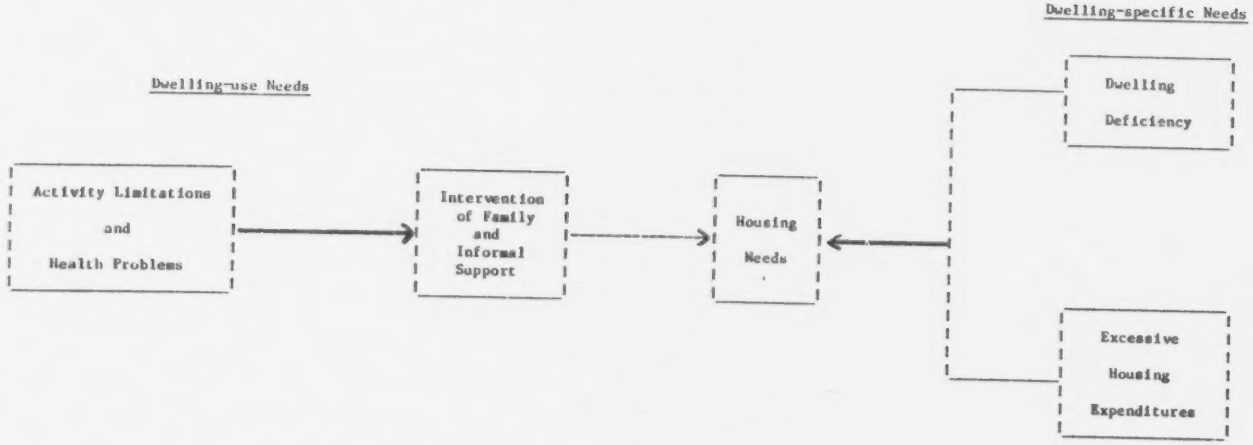

TABLE 1

INCIDENCE OF HOUSING DEFICIENCIES AND EXCESS EXPENDITURES--1979[a]

	Physically Deficient	Excess Expenditures	Deficient and Excess Expenditures
Nonelderly			
Total	7.6%	15.2%	2.1%
Renters	13.2	33.4	5.3
Owners w/Mortgage	3.1	7.9	0.5
Owners w/out	7.9	1.7	0.3
In Poverty	26.3	70.8	16.6
Renters	28.7	86.5	22.5
Owners w/Mortgage	17.1	73.2	10.1
Owners w/out	26.2	18.2	3.0
Elderly (65+)			
Total	11.5	18.4	2.4
Renters	17.2	55.3	7.8
Owners w/Mortgage	6.5	25.3	2.9
Owners w/out	10.1	4.5	0.4
In Poverty	29.0	41.0	8.7
Renters	31.0	74.9	17.7
Owners w/Mortgage	33.6	74.9	21.0
Owners w/out	27.4	17.7	2.3
Renters [b]			
Metro	12.1	58.8	6.9
Non-Metro Urban	21.6	54.6	7.3
Non-Metro Rural	40.1	37.3	13.3
Black	46.0	57.8	20.9
Other	13.3	55.0	6.0
Owners w/Mortgage [b]			
Metro	4.3	25.7	1.3
Non-Metro Urban	8.4	18.9	5.8
Non-Metro Rural	14.2	29.6	7.2
Black	24.7	44.3	12.5
Other	3.8	22.6	1.6
Owners w/out [b]			
Metro	6.8	5.1	0.4
Non-Metro Urban	8.4	4.4	0.0
Non-Metro Rural	18.3	3.4	0.8
Black	36.5	7.2	2.0
Other	8.3	4.4	0.3

Source: R. Struyk and M. Turner (1983), Table 3.

a. Only unassisted households are included in these figures; see Annex A for definitions.

b. Elderly-headed households only.

those used by HUD and they are listed in Annex A.) Moreover, we limit the population considered to those households not then participating in federal or state housing programs -- some 14.0 million elderly-headed households.

Among the elderly, a fairly clear ranking emerges running from those having the worst housing situation to those having the best. Impoverished renters and impoverished owners with mortgages are at the low end and non-poverty owners with mortgages and without mortgages are at the higher end. Differences by location exhibit a familiar pattern, with the incidence of deficiencies rising steadily as one examines successively more rural locations. This pattern holds across all tenure groups. The incidence of excessive expenditures is more varied, but generally tends to be lower in rural areas.

The relative disadvantages of black households is strikingly clear. Their units continue to exhibit extremely high levels of deficiencies. The incidence of excessive expenditures is also higher for blacks than for other households, especially among renters, but the differences are generally small in comparison to the divergence in dwelling deficiency rates between the races. Finally, although not shown in the table, it is worth noting that there is little difference in the rate of deficiencies among the elderly aged 65-74 and those 75 years old and over.[1,*]

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1. Struyk-Soldo (1980), Table 3-6.

* Full references appear at the end of the paper.

To summarize, in 1979 there were about 1.61 million elderly-headed households living in dwellings that would be characterized as being physically deficient and about 2.58 million spending an excessive share of income on housing. Since only about 340,000 have these problems in common -- meaning that many are spending a large fraction of their incomes to live in decent housing -- a total of about 3.85 million have a dwelling-specific housing problem. This is 28 percent of all elderly households. The incidence among those below the poverty line is much greater: of the 2.66 million elderly-headed households in this group, 61 percent have at least one of these problems.

Dwelling-use problems. While it has been long recognized that those whose activities are limited by health problems or disabilities are less able to function effectively in their homes without assistance, national housing policy has only recognized this fact to a limited extent. In considering policy options for aiding those with such problems, where necessary, one must know the size of population needing assistance. A key point to note at the outset is that dwelling-use problems can be ameliorated by supportive services, modifications made to the unit that facilitate its use, or both.

Here we give two estimates of the number of households with dwelling-use problems needing help, which are intended to bracket the actual number. The more generous definition is one which counts all of those who have a functional impairment due to disability or health problems. Applying this type of criterion to data from the 1979 National Health Interview Survey, one finds that about 12 percent of persons age 65 and over have a need for some form of supportive services

35-586 O—84——5

in their homes -- 7 percent of those age 65 to 74, and 21 percent of those age 75 and over.[1] If the same rate applies to elderly-headed households, this implies about 2.0 million households are in this category.[2]

The incidence of need defined in this way is greater for women than for men (in both age groups), greater for blacks than for others, and apparently greater for those with lower incomes. I say apparently because it is possible that many of those with low incomes in 1979 had spent their way down to this level through expenditures for medical and supportive care.

A more conservative (and possibly more accurate) estimate of the number needing supportive services can be obtained if we look at the share of those who have a functional limitation who are receiving formal care services, i.e., services provided by an agency, whether paid for by the recipient or not. This type of calculation has the advantage of deleting those who receive essential services only from family members, neighbors, and friends. Nationally, about 25 percent of the elderly who report a functional limitation are receiving formal services. Applying this rate to the 2 million households noted above yields a figure of about 500,000 households who require support services provided by a formal agency.

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1. See Annex A for the actual definition employed, and Annex Table B.2 for more complete figures. This discussion is based on work by Soldo (1983).

2. This procedure seems to be reasonable, given that using a similar definition of impairment Newman (1983) found about 13 percent of the elderly-headed households had at least one member with such an impediment.

This figure, however, is probably too low for two reasons. First, certainly not all those who need such services are receiving them. Second, some persons are now in long-term care institutions who would not be there if such services had been available to them. Evidence of this appears in the analysis of the determinants of institutionalization. Those who live alone are institutionalized at higher rates compared to elderly in multi-person households, even after controlling for health status and activity limitations.[1]

All in all, one might take an estimate on the order of 750,000 elderly-headed households as needing formal supportive services. Additionally, one and one-half times that number need and receive informal services -- either from sources within the household or from outside. Public policy should be structured so as to complement informal services, not replace them, and there are indications of how formal services might be provided to achieve this objective.[2]

It is also important to note that when one examines the determinants of the likelihood of a person receiving formal supportive services, the dominant factors are the extent of the person's disability and the absence of informal services. Interestingly, after controlling for these conditions, income by itself is not an important factor, suggesting that over some range public programs and informal assistance are reaching many of those in greatest need of supportive services.[3]

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1. Weissert and Scanlon (1983).

2. See Urban Systems Research and Engineering (1982).

3. See Soldo (1983) for details.

Thus, service recipiency seems to be largely determined by incapacity and lack of informal assistance.

In general, then, the patterns of dwelling-specific and dwelling-use needs are quite different. Whereas dwelling-specific problems are strongly income-related and little associated with age, dwelling-use problems are related to age and physical impairments but not particularly to income.

Dwelling modifications. The need for some types of supportive services can be eliminated by various changes to the dwelling which can compensate for particular functional impairments. These range from the installation of grab-bars and easy-to-grasp doorknobs and other hardware to specially equipped telephones to bathrooms and kitchens remodeled to accommodate wheelchair use. In other cases, such modifications can reduce the need for supportive services and thus complement their provision. The best estimate of the probable need for modifications -- beyond those already occupied by some 700,000 elderly-headed households -- is on the order of one million units.[1] As indicated above, these are not in addition to the count of those needing some type of support services. If we assume that the needed modifications are concentrated among those with the greatest impairments (who are also those most likely to be receiving formal supportive services), then about 250,000 households need to occupy units with some special features who are not also receiving formal supportive services.

1. These figures are taken from Struyk (1982).

The overlap between dwelling-specific and dwelling-use problems. Newman has used data from a supplement to the Annual Housing Survey to estimate that about 17 percent of the elderly-headed households with a person having an activity limitation reside in a unit that is physically deficient.[1] Note that this rate is substantially higher than the 10 percent rate for elderly-headed households with no members with such limitations, suggesting that households with an impaired member have greater difficulty maintaining or affording decent housing. This rate implies that in 1979 there were some 340,000 households in the group with both dwelling deficiencies and dwelling-use problems.

Similar calculations can be done for the overlap between those with excessive housing expenditures and a member with an activity limitation. This yields an estimate of 540,000 households with the combined problem.[2] Again, those households with an impaired member have a higher incidence of this problem than do other elderly households without such a member.

Summary. The figures in Table 2 summarize the information compiled thus far on the number of elderly-headed households with various housing-related needs. As implied earlier, these are order-of-magnitude estimates designed to give a general picture of the present situation. An encouraging point is that very probably less than a million

1. Newman (1983) uses the same definition of dwelling deficiencies used earlier in this paper. Figures are for 1978.

2. In doing this calculation, the rate was applied only to those elderly-headed households not participating in a housing program, the general assumption being that they would not have excessive expenditures on housing.

TABLE 2

SUMMARY OF HOUSING NEEDS OF ELDERLY-HEADED HOUSEHOLDS, 1979

Type of Need	Thousands of Households
Dwelling-Specific Needs	
Deficient dwelling	1,610
Excessive housing expenditures	2,580
Dwelling-Use Needs	
Supportive services	
Generous estimate	2,000
Stringent estimate	750
Dwelling Modifications	
Including those needing supportive services, stringent definition	1,000
Excluding those needing supportive services, stringent definition	250
Overlap Between Dwelling-Specific and Dwelling-Use Problems	
Supportive services (generous definition) and:	
Deficient dwelling	340
Excessive housing expenditures	540
Supportive services (stringent definition) and:	
Deficient dwelling	128
Excessive housing expenditures	140

households are characterized as having both dwelling-specific and dwelling-use needs. On the other hand, there are large additional groups that have one or the other type of need. Finally, a cautionary note: these figures are for 1979. The sharp increases in the number of elderly that will occur in the years ahead, as well as the greater share that will be in the older, more frail group of elderly is well-known and should be kept in mind when thinking about possible policy interventions.

Federal Intervention

The Congress in the past, through various legislation, has taken the view that all of the nation's elderly deserve a basic level of well-being and dignity. The housing-related problems outlined above have been singled out for explicit consideration over the years, as situations that are intolerable. Still, adequate funds to aid all those in need have not been forthcoming. Indeed, the limited resources available to address various high national priorities is a fact of life with which we all must live. The purpose of this section is to outline a framework within which a federal response to these problems can be considered and to sketch a couple of specific interventions that may be worth pursuing further.

A policy framework. In the previous section we saw that dwelling-specific and dwelling-use problems often occur independently. Nevertheless, in a substantial minority of all cases, they occur together. Moreover, it seems probable that as dwelling-use problems become more acute, the incidence of dwelling-specific problems will

increase rapidly. Activity limitations by a family member (and the energy of required others in the household to provide informal care) means that dwelling upkeep will likely be diminished. Likewise, drawing down on assets to pay medical bills and for formal care will lower incomes, possibly to the point at which housing expenditures become "excessive."

The challenge is to design a programmatic response that is flexible enough to deal with the variety of need mixes and ability-to-pay circumstances that will be encountered. If the response is properly designed, it may well permit savings in the total public resources going to the elderly as better options to institutional long- and short-term care are utilized. In a number of instances, for example, in-home services have been found to defer institutionalization and to reduce the number and length of visits to acute-care hospitals.[1]

Three principles should guide the design of the general policy response. First, cost-effectiveness is essential. The criterion here is that the new approach be no more costly and at least as effective as present programs. In this calculation, costs include assisting additional households beyond those to whom the assistance is actually directed. Particularly at issue is the substitution of formal for informal supportive services. Also, achieving cost-effectiveness may well require a degree of coordination among services far beyond that now occurring, especially between housing and support services which are presently administered independently in most cases.

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1. See, for example, Miller and Walter (1983).

Second, to the maximum extent feasible, the programs should be constructed to permit a range of choice to the elderly in terms of the solution adopted: remaining a homeowner or shifting to rental quarters; community-based versus institutionally-based services. Of course, the recipient may have to pay a larger share of the cost for more expensive solutions; but the choice should still be present.

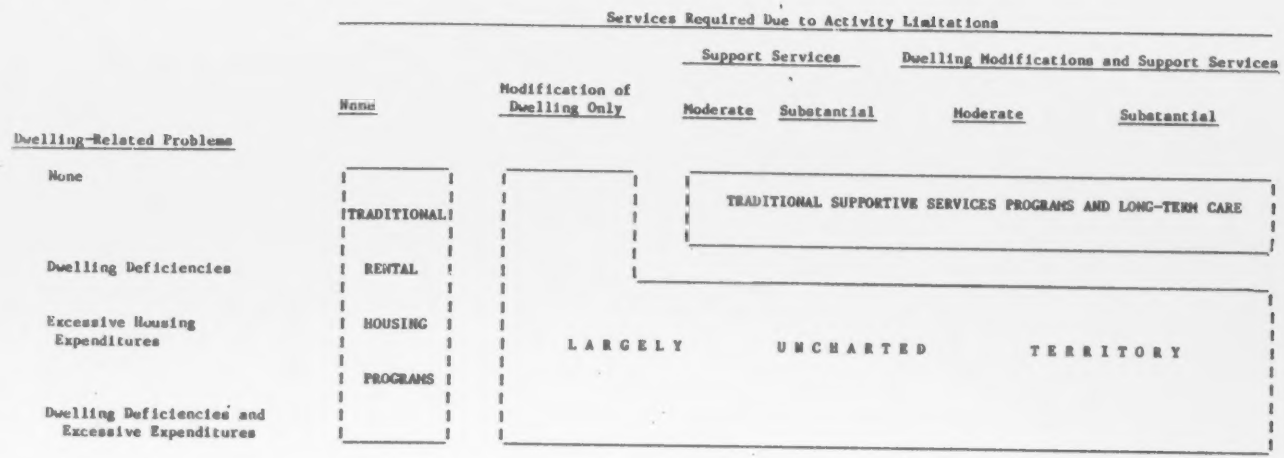
Third, the options should be structured so as to foster timely adjustments in the "housing-bundle" selected. As noted at the beginning of this statement, the housing needs of the elderly can be highly dynamic. Solutions offered in responding to those needs ought to encourage timely changes in the basic housing situation -- for example, from living alone in a single-family home to an apartment in a congregate housing project.

The key idea behind the framework set forth here is that it is essential to tailor solutions to fit each of a range of housing-related needs. To achieve this matching requires that one differentiate both among types of housing needs and among recipient populations. The various types of housing-associated needs were discussed at length above. Two household attributes seem key: economic resources (and hence the ability to pay for services) and mode of tenure, i.e., owner-occupancy versus renting. The latter strongly affects the efficiency with which many support services can be provided, as well as the range of options available for coping with dwelling deficiencies and excessive housing expenditures.

Figure 2 gives a simplified depiction of the arrangement today of federal policies for meeting the housing-related problems of the

FIGURE 2

TRADITIONAL FEDERAL POLICIES FOR HOUSING-RELATED NEEDS OF THE ELDERLY



elderly. The central point is the essentially independent administration of programs dealing with housing problems and those providing support services. The joint provision of services is largely "unexplored territory," with the exceptions being the fledgling congregate housing program and some local efforts in which Federal resources are effectively coordinated. Conspicuous gaps in coverage are evident -- such as the absence of dwelling-specific aid for homeowners, and no programs to help with dwelling modifications.[1] Likewise, the targeting of resources to lower income groups is mixed: it is probably good in housing and much weaker in support services.[2] In short, the present system is a patch-work and one that only infrequently provides the right aid to persons needing both housing assistance and supportive services.

In contrast, Figure 3 summarizes a more tailored approach. The key here is explicit differentiation among types of needs and types of households requiring services.[3] The role of government (which is listed in each box in the matrix) is also defined quite differently, depending on the household's ability to pay for services. For example, for households needing extensive support services, a voucher for a

1. Exceptions to this dictum do exist. Dwelling-specific aid is provided federally in the weatherization and heating payments programs. Additionally, CDBG funds can go for both purposes mentioned.

2. Services provided under the Older Americans Act are not means tested. Those funded by the Social Services Block Grant have varying income limits set by the states, but almost universally these limits are less stringent than those in the housing programs.

3. To simplify the figure, some joint problems combinations have been omitted, such as dwelling deficiencies and excessive expenditures.

FIGURE 3

POSSIBLE TYPES OF PUBLIC INTERVENTION TO IMPROVE THE HOUSING SITUATION OF THE ELDERLY

"DWELLING-SPECIFIC PROBLEM"	Extent of Activity Limitation Requiring Non-Family Assistance -- "Dwelling-Use Problem"			
			Requires Support Services	
None	None	Requires Dwelling Modification Only	Moderate	Extensive
- Low Income	A.	B. (1) Grants for modifications; for renters assistance finding specially equipped unit, specialized, subsidized rental units	C. (1) Local service provision, some federally supported	D. (1) Congregate services voucher; Medicaid waiver for homeowners
- Moderate		(2) Loans for modifications; renters, as above	(2) Local service provision on co-payment basis	(2) Same as above
- Middle Income		(3) Assistance in finding reputable contractors; housing referrals for renters	(3) Referral services	(3) Private congregate services referral
Dwelling Deficiencies				
- Low Income	E. (1) Homeowners: subsidized dwelling repair and maintenance program Renters: housing allowance, relocation assistance	F.	G.	H. (1) Same as (D,(1))
- Moderate Income	(2) Homeowners: loans; RAMs Renters: relocation assistance, housing referral	Same as (B) above, combined with elements of (E)	Same as (C) above, combined with (E)	(2) Congregate service vouchers; Homeowners: (D,(2)) with loans, RAMs for repairs
- Middle Income	(3) Homeowners and Renters: various kinds of referral assistance			(3) Same as (D,(3))
Excessive Housing Expenditures				
- Low Income	I. (1) Homeowners: weatherization grants (if appropriate) or housing allowance Renters: housing allowance or more specialized housing projects	J. Same as (B) above, combined with elements of (I)	K. (1) Congregate housing voucher for renters. Homeowners: local service provision plus (I,(1))	L. (1) Congregate services voucher for renters; Homeowners - Medicaid waiver plus housing allowance combined with counseling
- Moderate Income	(2) Homeowners and Renters: Counseling on options; possibly housing allowance in highest cost areas		(2) (C,(2)) and (I,(2)) combined; in some cases congregate vouchers where this is more cost effective than combination of other approaches	(2) Same as above
- Middle Income	(3) Homeowners and Renters: counseling about options		(3) (C,(3)) and (I,(3))	(3) (D,(3)) and (I, (3))

congregate housing program (described below) is appropriate; but only referral services to market-rate programs are necessary for middle income households. Similarly, for those homeowners needing dwelling modifications only, grants make sense for those in the low-income group, while referrals to contractors and possibly reverse annuity mortgages are the best form of government assistance to the more well-to-do.

In cases in which the household has both dwelling-specific and dwelling-use problems, greater coordination is essential. For renters, such needs will frequently be efficiently addressed through a congregate services program, either subsidized or at market rates. For homeowners the solution varies with their ability to pay and their desire to remain in their home. For lower income homeowners, in-home services provided through Medicaid (in states which have applied for this waiver) and housing assistance via a housing allowance may be economically feasible.

The lead in the provision of a number of services listed in the figure is placed at the local level, although federal support may be instrumental. The superiority of local organizations and solutions seems likely for most referral services, grants for housing rehabilitation and modifications to owner-occupied dwellings, and the provision of modest amounts of support services. At the same time, however, one needs to be concerned that those nominally eligible for such assistance actually fall within an active service area. Spotty coverage -- both between and within jurisdictions -- has been a hallmark of local initiatives for the elderly.

In general, better targeting of housing assistance resources to need will be essential. For example, occupancy of specially designed housing projects (built under the public housing and Section 202 programs) should be limited to the frail elderly, with priority among them going to those with dwelling-specific problems and more extensive support services needs.[1] (This assumes that complementary funding for services is available.) Also essential is the wider availability of congregate services and initiation of a housing allowance program for elderly owners to fill glaring gaps in the solutions available.

Congregate vouchers and homeowner housing allowances. One idea deserving careful study is a housing voucher program for the frail elderly, which might be called the Independent Living Voucher Program. The voucher would entitle the holder to occupy a unit in a congregate housing facility -- a housing project providing independent living with the necessary nonmedical support services, e.g., some community provided meals, chore and recreation services. The voucher would cover the cost of both housing and support services. Households might contribute 40 to 50 percent of their incomes to pay for services, since it includes housing, most meals, and other services. The projects would be privately developed, financed, owned and operated. Vouchers might only be usable in the projects, both because of economies of scale in service provision in high user density situations and to control the amount of

1. There is some evidence that cost-cutting measures implemented by HUD in the past few years may be making such specialization more difficult, as some public spaces, elevators and other special features are being eliminated. For details, see Turner (1984).

substitution of government for family-provided help in a more dispersed arrangement. Projects would be encouraged to serve voucher holders as well as "market rate" households. Admission would be restricted to those over age 75 (a good shorthand indicator of supportive services needs[1]) or those who are certified to need supportive services.

The potential advantages to such housing assistance are several. Congregate facilities can offer an appropriate alternative to intermediate care facilities for those no longer able to live fully independently. Several years on average might be spent in the congregate project. In this sense, congregate housing could result in cost savings over the present system of long-term care. This approach also deals with both dwelling-specific and dwelling-use problems.[2]

Clearly, however, these apparent advantages of such an alternative must be carefully analyzed before it is further advanced. A host of questions come readily to mind:

- What services should be included in the package, especially in light of a mission to offer a cheaper alternative (where appropriate) to intermediate care facilities?
- Will private developers respond to supply the needed services? What was the experience in the expansion of intermediate care beds under the impetus from Medicare? What type of guarantees will be necessary, if any?
- What is the likely cost on a per unit month basis? How could one objectively price a given "bundle" of services, i.e., could the equivalent of the fair market rent used in the Section 8 Existing program be developed? Would a gap-type payment formula make sense?

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1. See Lawton (1983) for explanation and discussion.

2. Additionally, reliance on private providers means lower federal short-term commitments of budget authority to finance the construction of projects that are necessary under the traditional programs.

Importantly, the congregate voucher program should be available to those who are homeowners at the time they apply as well as renters. Absolute limits on assets should be avoided, although actual and imputed income would be counted as income for determining eligibility and computing a subsidy, if any.

The second major gap in the present array of federal activities is assistance to elderly homeowners who have dwelling-specific problems, either solely or in combination with dwelling-use problems. High income households, and those with large amounts of house equity, are often quite capable financially of dealing with their problems -- although Reverse Annuity Mortgages could greatly facilitate using the equity in their homes. Counseling about RAMs and help finding reliable contractors are other types of assistance that could be very valuable in making the necessary arrangements to "unlock" these households' own resources.

Lower income - low home equity homeowners are in more difficult circumstances. Housing allowances for homeowners have been found to be quite effective in dealing with dwelling-specific problems. The evidence from the long-term open-enrollment demonstrations in Green Bay, Wisconsin and South Bend, Indiana provide fairly clear evidence that improved dwelling maintenance occurred and that excessive housing expenditures were eliminated.[1] Moreover, because of the inclusion of imputed income from home equity in the definition of program income, the cost of payments was lower for homeowners than for renters. One point

1. See Lowry (1983), Chapter 5.

of concern, however, is that homeowners tended not to enroll in the program as readily as renters; on the other hand, once enrolled they succeeded in eventually qualifying their dwellings at higher rates than renters. Still, only about one-third of the eligible elderly homeowners participated. Thus, strong out-reach should accompany the use of such a program.[1]

For lower income homeowners who need a substantial amount of supportive services, the coordination of housing allowances and supportive services in principle appears feasible. In fact, a notice about the potential availability of the allowance could be a routine part of the procedure notifying the household of the granting of the in-home Medicaid-supported services. Still, one must be concerned with the combined cost of Medicaid support and the housing allowance compared to providing those services in a congregate services environment. This question certainly needs to be carefully examined. If the congregate approach appears to be more cost-effective, the overall contribution of the household might be made somewhat higher if it elects to remain in its home, although the differential should not be made too extreme in order to preserve the reality of choice.

It is important to note that under the at-home service waiver, the higher income limits used for institutional care eligibility apply.[2]

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1. Ibid., Chapter 4. Also, Zais, Struyk, Thibodeau (1982), Chapter 6.

2. Under the federal-only program those are set at 300 percent of the SSI eligibility limit of about $4,100 for an individual ($5,900 for a couple). Figures are for 1984. The projected poverty line income for individuals is $5,001 and for couples is $6,309.

Hence, moderate as well as low income households are eligible.[1] Because of the requirement that in-home services only be provided as an alternative to care in a long-term care facility, the targeting of resources to those needing them should be quite strong. On the other hand, working out the joint contribution rates to the two programs could be somewhat complicated.[2]

Conclusion

Meeting the housing-related needs of the elderly is complex and challenging, both because of the diversity of the needs themselves and because of the way in which the provision of housing assistance and aid for support services have been organized. The Select Committee is in a unique position to rise above the jurisdictional issues to formulate an overall strategy for dealing with these problems. The challenge is to design a strategy that is cost-effective by closely matching the assistance provided with the unmet needs of the elderly. Likewise, more explicit attention should be given to focusing on those groups in greatest need. In this regard the higher incidence of both dwelling-specific and dwelling-use problems of blacks and those in rural, non-farm areas is especially striking.

1. It is very important to note that Medicaid requires a "spend down" when incomes are above SSI eligibility levels. That is, to receive Medicaid requires the household to spend the difference between its income and the SSI eligibility level income on these Medicaid expenses, thus impoverishing itself. For details on benefit levels by state, see Committee on Ways and Means (1984), pp. 380-83.

2. The complication arises for those who have incomes above the SSI limit who must, in effect, pay the difference between their total income and the SSI cut-off for the Medicaid-provided services (see previous footnote). Presumably, the housing allowance would be based on the household's net (i.e., after medical expenditures) income. In any event, the possibility for coordination seems good.

ANNEX A

DEFINITIONS

1. Dwelling deficiency. See Table A-1. Specifics of the definition were dictated by the data available in the Annual Housing Survey. This definition is the same as that employed by HUD.

2. Excessive Housing Expenditures. Here we follow HUD's lead so that our results will be consistent with other tabulations. Excessive burden is defined separately for renters and homeowners. For renters, gross rent (contract rent plus utilities paid by the tenant) above 30 percent of gross household income is considered excessive. For owner-occupants, out-of-pocket expenditures for housing (excluding expenditures for maintenance and improvements) above 40 percent of family income is considered excessive. The higher standard for homeowners is based on the tax advantages accruing to homeowners and on the capital gains-producing investment embodied in their housing expenditures. (See Feins and White (1978) for more discussion of this point.)

3. Need for supportive services. Two definitions are used, based on data in the 1979 National Health Interview Survey. The "generous" definition, developed by Soldo (1983) includes any person with at least one of the following:

   - needed or received help with at least one of the seven Activities of Daily Living (ADL)
   - needed or received help with at least one of the four Instrumental Activities of Daily Living (IADL)
   - was not able to perform one or more of the ADL functions
   - stayed in bed all or most of the time
   - needed help with urinary or bowel devices.

   The "stringent" definition includes those persons in the group defined by "generous" definition who receive formal home care services.

TABLE A-1

DEFICIENCIES WHICH CAUSE A HOUSING UNIT TO BE JUDGED PHYSICALLY INADEQUATE - BASED UPON AHS ITEMS, REVISED DEFINITION (1981)
(HUD/Simonson Definition)

Type of Deficiency		Description of Deficiency
Plumbing	1.	Lacks or shares some or all plumbing facilities. The unit must have hot and cold piped water, a flush toilet, and a bathtub or shower -- all inside the structure and for exclusive use of the unit.
	2.	Lacks adequate provision for sewage disposal. The unit must be connected with a public sewer, septic tank, cesspool, or chemical toilet. (Units with this deficiency are almost invariably defined as having a plumbing deficiency as well.)
Kitchen	3.	Lacks or shares some or all kitchen facilities. The unit must have an installed sink with piped water, a range or cookstove, and a mechanical refrigerator -- all inside the structure and for exclusive use of the unit.
Physical Structure	4.	Has three or more of five structural problems: leaking roof; open cracks or holes in interior walls or ceiling; holes in the interior floors; either peeling paint or broken plaster over one square foot of an interior wall; evidence of mice or rats in last 90 days.
Common Areas	5.	Has three or more of four common area problems: no light fixtures (or no working light fixtures) in common hallway; loose, broken, or missing stairs; broken or missing stair railings; no elevator in building (for units two or more floors from main building entrance in buildings four or more stories high).
Heating	6.	Has unvented room heaters which burn oil or gas. If unit is heated mainly by room heaters burning gas, oil, or kerosene, the heaters must have flue or vent.
Electrical	7.	Lacks electricity.
	8.	Has three out of three signs of electrical inadequacy: One or more rooms without a working wall outlet; fuses blown or circuit breakers tripped three or more times during last 90 days; exposed wiring in house.

Source: Simonson (1981), pp. 84-85

ANNEX B

SUPPLEMENTAL TABLES

TABLE B-1

TENURE DISTRIBUTION AND INCIDENCE OF POVERTY BY TENURE STATUS AND AGE OF HOUSEHOLD HEAD IN 1979 [a]

	Renters	Owners with Mortgages	Owners Without Mortgages	Total
All Households				
Elderly	24%	8%	68%	100%
Nonelderly	34	43	23	100
Share of Tenure Group in Proverty				
Elderly	28%	12%	17%	19%
Nonelderly	26	3	8	9

a. Only households not receiving housing assistance are included.

TABLE B-2
PREVALENCE RATE PER 1000 65+ OF NEED FOR HOME CARE [a]
FOR SELECT CHARACTERISTICS, BY AGE: 1979

Characteristics	Total	Age 65 - 74	Age 75+
Total	121.0	69.9	211.0
Race			
White	116.0	64.0	207.0
Black	168.0	127.0	245.0
Other	148.0	82.0	320.0
Sex			
Male	91.0	55.3	166.6
Female	141.0	81.1	237.2
Region			
Northeast	129.0	78.0	219.0
North Central	104.0	54.0	188.0
South	130.0	80.0	221.0
West	118.0	62.0	216.0
Place of Residence			
Central City, SMSA	123.0	77.0	204.0
SMSA, not Central City	113.0	64.0	203.0
Rural, nonfarm	132.0	74.0	230.0
Rural, farm	72.0	25.0	164.0
Living Arrangements			
Alone	124.0	77.0	177.0
With Non-Relative	246.0	132.0	392.0
With Spouse	82.0	55.0	163.0
With Other Relative	243.0	134.0	346.0
Medicaid (Last 12 Months			
Yes	292.0	195.0	412.0
No	105.0	60.0	189.0
Personal Income (In 1978 dollars)			
$ 2,000	175.0	b	b
$ 2 - 2,999	287.0	b	b
$ 3 - 3,999	200.0	b	b
$ 4 - 4,999	102.0	b	b
$ 5 - 5,999	59.0	b	b
$ 6 - 6,999	46.0	b	b
$ 7 - 9,999	56.0	b	b
$10 - 14,999	21.0	b	b
$15,000+	28.0	b	b

a. Consult Annex A for definition.

b. Insufficient number of cases for reliable estimation.

Source: Estimates from the 1979 National Health Intervew Survey prepared by Soldo (1983).

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Chairman HEINZ. Thank you very much, Ray, for a very concise version of a much more fulsome statement. We appreciate your concise summary.

Let me ask Ms. Feingold a question. You mentioned that you provide a lot of services to your 1,200 elderly tenants. Could you run through some of the services or the list of services you provide? And second, to what extent any of those people pay for those services?

Ms. FEINGOLD. First of all, let me be clear: We do not provide very much of this service ourselves. We utilize a wide range of community service arrangements, many of them funded from the AAA agency. I could not get from the AAA agency accurate numbers because our request came at exactly the wrong moment. They're computerizing their data and can't get them either from the computer or manually.

I can give you the statistics that our largest provider of services, the Jewish Family and Children Service has given us. Currently about 300 of the residents in our Brighton complex are receiving homemaking services. Many of our residents are also served by visiting nurses and home health aides. In addition, at any one time, 50 to 60 of our residents are receiving social services. Over the course of the year, 200 to 300 residents will see a social worker for some problem or another.

We have calculated that to provide the services which this agency alone provides us, we would probably need to put six social workers on our payroll. Instead, we have available a group of 15 to 20 people who are specialists in the areas in which they deal, including a Russian language social worker. We have a large population of new Soviet emigres, who have been in this country 4 years or less. They are learning to speak English. Some of them are now taking citizenship training, but when they need social service, it's helpful to have it in Russian.

Chairman HEINZ. If you would just expand what you started to give us, the number of people and how much those services cost. In an ideal world, where HUD had a larger budget, a much larger budget, I guess, what should HUD be paying for as opposed to HHS or area agencies on aging or anybody else? What should HUD actually be providing in the way of services or services support?

Ms. FEINGOLD. HUD supports my 2½ half staff people through my approved administrative budget. HUD should absolutely be required to cover service coordination. We run a beautiful housing project. It would not look like that if I did not have a social service coordinator. But what goes into making it look like that is a well serviced population, which is able to live productively and independently—albeit some of them are over 100 years old.

We have, for example, 20 families, 20 two-person households where one person's condition clearly qualifies for nursing home care. But their spouse or sibling or whoever it is that's living with them is able, with a range of services, to keep them going.

It is my in-house staff that makes it possible for those residents to keep going and get the right outside services they need. Thus, in my estimation, the in-house service coordinatior staff should be a HUD housing supported function.

We have recommended that a housing management chooses also to be the provider of services, it may put social workers on its payroll. It may also be appropriate for that to be supported through the HUD budget. That is the kind of flexibility which the HUD programs should be amended to make possible.

Chairman HEINZ. One of the recommendations you made was that the 75-unit limit on 202's be lifted. If it had to be lifted to another ceiling, what should that ceiling be? Or, turn the question around, your point was that you did not necessarily reach the point of maximum efficiency, vis-a-vis staff on site if you limited elderly housing projects to 75 units. Can you give us some sense as to how low that 75 is?

Ms. FEINGOLD. I think that is a local issue. We have one building of 125 units that I don't think functions very well. I am trying right now to build an addition to that unit of another 75 to 100 units.

Our original complex in Brighton is 710 units, and that creates what I consider to be a critical mass. This is in the city with a market for that. Obviously, any housing development needs to be evaluated in terms of its market, and if one is in a rural area or a suburb where only 35 or 40 or 50 units is all that can be marketed, that becomes a ceiling of its own.

I don't think I would put an artificial ceiling on an elderly housing project. I would allow the sponsors to make a determination as to what they can market and manage best.

Chairman HEINZ. All right. Local option.

Ms. FEINGOLD. Yes.

Chairman HEINZ. Dr. Struyk, we've heard a great deal of testimony about the kinds of shelter and service options we need to provide for the frail elderly, including several that may be more cost effective than the current patchwork which we have described. Do you think something like the independent living voucher for a low-income frail elderly target group is affordable?

Dr. STRUYK. Affordable to the country?

Chairman HEINZ. Yes.

Dr. STRUYK. The short answer is yes, and let me give you a couple of very crude numbers that go with this response and try to explain how I got them.

I think that the resource cost of serving those who would likely be eligible and participate under such a program is in the order of $3 billion, $2.7 to $3 billion. That's resource costs. That's not cost to the Government.

Depending on what contribution rate you set, it could be substantially lower. Under some calculations I have done, I get a figure of about $1.7 billion.

I think it's important to tell you how I got my numbers, because they're not argument proof. I took the payment standard for a one bedroom unit in the HUD current voucher program and took that as what it would cost for the shelter. I then added the cost of congregate services that the very preliminary numbers out of the HUD study suggest. Those two numbers are monthly $322 for shelter, total resource cost, and $240 per month for services, which gives you a total resource cost of about $560 a month.

I take a tenant income figure, which is the same one that HUD uses, of about $5,000 and devote half of that to payments. The reason I'm using half instead of 30 percent is because the congregate includes two meals a day, 6 days a week, plus personal care services.

Let me just make one side comparison, that $562, if it's even in the right ball park, compares with intermediate care facility costs of $30 to $50 a day or $900 to $1,500 a month. So even if my figures are a bit low, it will not affect my basic point.

I think that the number of households who would be eligible for this program using the HUD 50 percent of median income cutoff is in the neighborhood of 800,000. I can talk about how I got this figure later, if you wish. But let me finish the general story first. The critical question is participation rates. The one housing entitlement program we've had to look at is the one demonstrated in the experimental housing allowance program in Green Bay and South Bend. And the highest conceivable participation rate you get there is about 50 percent of people over 65, and I think that's a reasonable figure here. It's probably low because the benefits are higher, because you get the congregate services as opposed to just a grant for housing. But on the other hand, we're talking about congregate projects, which would mean that people would have to move into the project if they were initially in different units, which would make them less attractive. So, a reasonable figure appears to be 50 percent.

So that gives me 400,000, both eligible and participating. When I multiply that number by $560 a month, I get total resource costs of about $2.7 billion.

If the orders of magnitude spoken about earlier in terms of cost savings in long-term care institution or acute care institution treatment costs are anywhere in the ballpark, then the country cannot afford not to expand the congregate program. It's a money saving proposition. There is, however, always going to be some slippage in targeting and I would think that on balance this looks like it would meet a reasonable test of efficiency.

Chairman HEINZ. The $2.7 billion, and you point out that that's before you modify it for any contribution rate, as I understand it.

Dr. STRUYK. That's correct.

Chairman HEINZ. Would it be spent on people right now who are not getting these services met in any formal sense? Therefore, is it a net increase in service delivery? Are you trading off someone moving from a nursing home or preventing an institutionalization?

Dr. STRUYK. I got the 800,000 number in two different ways. One way makes a fairly generous estimate of a couple of hundred thousand people who would not be institutionalized, and therefore, be receiving these services. I tried not to low ball the eligibility number.

Chairman HEINZ. Of that 800,000, you're saying that 200,000 would otherwise be institutionalized within what, a fairly short period? And if so, how short?

Dr. STRUYK. These are intermediate care facility occupants, and those are not terribly short term on average. They're long term.

Chairman HEINZ. And in those cases, you're talking of cost in the range of what, $40 a day?

Dr. STRUYK. $30 to $50 a day.

Chairman HEINZ. So clearly this is significantly less expensive than the intermediate care.

Well, you have both, Ms. Feingold, and Dr. Struyk, given us some very good statistics, and some very good information from the real world. Is there anything either of you would like to add? Ms. Feingold? I have never known you to be at a loss for words.

Ms. FEINGOLD. I guess the one thing that I would like to add is that we are here on behalf of the elderly. There are a number of us here who advocate for housing generally, including Dr. Struyk and myself. The problems that we are addressing is the need for services and the need for continuation of support for programs are certainly equally true of family housing.

We want to be sure that we don't find ourselves in the position where support for elderly housing is being used as an excuse for taking away or cutting back on the equally crucial needs of family housing.

Chairman HEINZ. Although as chairman of the Committee on Aging that is slightly beyond my immediate brief, let me comment on that. In many respects I think elderly housing can acclimate people to the notion of federally assisted housing in an area where none has existed before.

There are many communities that may not want federally assisted housing, often they are ethnically very strongly identifiable. This is true in my hometown of Pittsburgh, which, as we always say, is a town of neighborhoods, Croatians, Serbians, Polish, Lituanians, Latvians. You name it, we have it—we don't have quite as many Irish as Boston yet. But we have found often that the way to break down the prejudices and stereotypes about any kind of Federally assisted housing is with elderly housing. So it is not necessarily that it's an excuse. Sometimes it can be a lever that overcomes people's irrational fears.

Dr. Struyk.

Dr. STRUYK. I would like to come back to a question you raised earlier about which functions belong to which agency, and in particular which should be funded by which agency. I don't think this is the right question.

I think that one agency or the other in any given project ought to have the full financial responsibilty and you want specialization on carrying out the oversight functions. That is, you want the HUD architects to worry about whether the building standards are correct, and you want the HHS people to worry about whether the services provided meet the minimum standards.

The real distinction comes possibly in terms of which agency receives the funds for HUD projects that already exist. And there I think you just really ought to try to give them the funds to carry out both functions. In the future, I don't care which agency gets it——

Chairman HEINZ. But they do. You and I may not care, but they care. And Dave Stockman cares.

Ms. FEINGOLD. I think the crucial thing here is that the funds be earmarked for services and service coordination. What you see so often is—and I see it in my own project—if the sewer backs up, everybody runs and fixes the sewer. If somebody needs social services,

it isn't so easy. Wherever the money comes from, it must be kept clearly for the purpose of coordinating and providing services.

Chairman HEINZ. The fear that exists in many quarters in Washington about doing anything innovative in this area is a fear of what in the Defense area they call cost overruns. Cost overruns have become as common as day-old bread on Sunday in the Defense Department.

But they are not unique to the Defense Department. We had a hearing on medicare's part B a few weeks ago, and that program, that's the physician's services under medicare, started out in 1965 and the cost of it was $1.8 billion; 10 years later, the cost of it had skyrocketed to, in 1975, $2.8 billion. I use the term skyrocket in quotes, because in 1985 the cost of that program will be $28 billion, even graphed on log paper, an incredible increase. So we are always working against the backdrop that if we create a program that really works, sometimes we design it so that it overperforms where the finances are concerned in alarming ways. What you tend to do is overburden the delivery system which always finds a way, somehow, of reacting the way economists say that it will—too great a demand will cause the inputs to react—which means the prices somehow go out of sight. That is, I think, the great fear that we have to contend with, and that's a rational fear. So I hope to work with both of you in figuring out a way to address that fear as we try and improve the kinds of services that we can make available to prevent what I call nursing homes without services.

Thank you both very much.

Ms. FEINGOLD. Thank you, Mr. Chairman.

Mr. STRUYK. Thank you.

Chairman HEINZ. Our last panel is Pamela Shea-Roger, James Firman, and Robert Chellis. Ms. Shea-Roger, would you be our leadoff witness?

STATEMENT OF PAMELA SHEA-ROGER, PARTNER, OKM ASSOCIATES, INC., BOSTON, MA

Ms. SHEA-ROGER. Thank you for inviting me to come today to talk to you about elderly shelter options. My name is Pamela Shea-Roger. And I am a partner in OKM Associates and president of the housing services group.

I know a lot of you and I am glad to meet you, Senator. For the last 13 years I have been working in the field trying to develop both services and housing options for the elderly that would do two things: Either prevent people from being institutionalized prematurely, or as we talked about with the congregate housing program, earlier, to get people who have been inappropriately institutionalized out of institutions and back into the community and living independently.

In addition to that, we're participating in several national research programs to take a look at the range of living options that are growing up at the grassroots level and at the State level that also provide different ways for the elderly to either age in place or stay at home as long as possible in the best way that they can.

Today I would like to talk about what some of those shelter alternatives are, but before that I would like to follow up on a couple

of points that Ellen made in regard to myths about the elderly that I think need to be talked about to make us realize what works for elderly housing options.

And the first one of these is the old stereotype that old people are all the same, that they need the same kinds of housing. And everybody knows that they are not all the same; we have people who are old who ran in the marathon; we have people who are old who are bedridden. I don't think the issue is whether we're alike or we're not alike or whether elderly are alike or not alike, but however people are going to be served, we need a diversity of options to serve people well.

The second part of that, and Ellen touched on this too, is that housing, just the physical building isn't the issue really at all. And I think everyone here today has been talking about the same thing.

A building by itself is nothing. What we're talking about is the building, the residents that live in that building, no matter how big or how small the building is, the management of that building, the services and the needs of the people, and I think all of us together have said the same thing.

All of that together we have called a shelter option, as opposed to a housing option. And I don't think again we can ever think about housing for the elderly, whether it's big 202 or small 202 as just the building.

But we have to think about it as the building, the residents, the management, the services, as a piece.

The second thing, and Ellen touched on this, too, and I think it's probably more important than anything else, is people often assume that as elderly people get older, and especially as they get frailer, they completely lose control or partially lose control over their own lives.

And this is definitely not true. I think what is true is that people need more help as time goes on. But because you need more help, that doesn't mean you sacrifice control. One of the things that Secretary Rowland and Secretary Anthony talked about this morning, and I think it's fascinating about the Massachusetts congregate experiment, we talked to almost every resident who is living in State-aided congregate housing in Massachusetts, and without exception each of those people said, "The most important thing for me in this program is that I control my own life."

Some of those people, like the man that Ellen talked about, are put in a wheelchair in the morning and put back in bed at night. The services that they receive are no different than the services that they would receive if they were in a nursing home, except for two things: One, it's cheaper to provide them in the community, and second, it's the issue of control. The residents control those services themselves. And in a nursing home, somebody else makes the decision for them.

So I think if we can remember those two things, that people, no matter what their service needs are, as long as they're mentally healthy, can control their own lives, and that we need a diversity of service programs.

We found a number of things looking across the country in our research about alternatives. Jim's going to talk about home equity

conversion, Bob's going to talk a lot about life care. So I won't go into those too much.

But probably about 73 percent of the people in this country own their own homes, and a lot of the programs that are growing up at the grass roots level are geared toward those people who own their own homes but they're house rich, and cash poor.

One housing option is the home repair program, where the elderly person needs a reliable way to get affordable home repair services. This is a great program, because it doesn't cost anybody a lot of money. In some towns, some cities, some States, the service itself is subsidized, but what we're finding is needed more than the subsidy to the service is the information to people about how do you find a good program, and how do you find a reliable contractor. It's not very expensive to provide that service.

Chairman HEINZ. How do you do that?

Ms. SHEA-ROGER. I don't know the answer to that. What a lot of States are doing who have funded the program to provide the funding for the home repair is that they're doing a list of contractors. And that list of contractors is then available to people who wouldn't be income eligible for the program, but still need to fix up their own homes.

There is a property tax reduction program in a number of States which is really good which reduces the elderly housing costs by doing abatements, refunds, exemptions, property tax reductions. And there are a number of States who are also doing that.

Home equity conversion I think is probably one of the most exciting programs and that's one Jim's going to talk about. But basically what it means is elderly people are allowed to borrow money against the value of their homes so that they continue to live in their own homes.

There are reverse annuity mortgage programs and those programs are when funds are lent to an elderly person so that they can stay and live in their own home, and then those funds are secured by a mortgage. So it's a little bit different than the home equity program.

A sale lease-back program is where the elderly person sells their home to someone else but takes the lease back on their unit, or their apartment or a part of that home. So that they continue to live in the same place.

There are many shared living programs across the country and almost all of these have grown up at the grass roots level, where two or more unrelated people share a single unit or some of the common facilities. There are home matching and home sharing programs where an older home owner can be linked with another elderly home owner, or with a young person to help to share their home and to defray some of the expense.

There are accessory apartment programs, and those were touched on this morning. Some real zoning problems there. Where within a person's house they build another unit, either that they can then move into themselves as the elderly person and rent the rest of their house, or that their family can build an accessory apartment so that the elderly person can move in and have some kind of family support and have it be less expensive.

There are the manufactured housing programs which are fairly new, and there is only one as far as I know that is tailored just for the elderly. This program is very much like what people used to call mobile homes. It just means the housing is made somewhere else and brought to the site, and stands apart from whatever the home is on the site. This is a very large program in Australia and some European countries. What it allows you to do, if you have enough room, is put a temporary unit on your site that can serve your mother or your father or whoever it is for the amount of time that they have to be there so the family again gets support. There are also some zoning problems with this program.

There are lodging houses, boarding homes, rooming houses, SRO housing, some of which have gotten very bad names, but which, in fact, if they are put together with good management and good services can serve another kind of population.

There are domiciliary care programs that serve people who are not quite as independent in terms of mental health functioning, and they provide a lot more social service and mental health service and are much more like what we think of as level IV's, but still much less expensive, and a much better quality of life than institutional care.

There are the life care, continuing care communities that Bob is going to talk about which are really exciting. And then there are services that are provided in the communities that are really direct services to the elderly who were just staying at home, channeling services, where the supportive services coordinator or somebody through an AAA or home care tries to help the elderly person manage all of the services that are available, because that sometimes is a little overwhelming.

There are adult day health programs, and I am really excited about those. We run three of those ourselves. They either help the elderly to try and stay in their own homes or help families keep the elderly person at home for as long as possible. And they meet both the physical, social and emotional needs of the clients. And then there is adult foster care which also keeps people in the community, and that's when a foster family, just like it would be for child foster care, provides room and board and personal care services for an elderly population.

I think these are some of the range of options that are available. Everybody has talked about the fact that our elderly population is rapidly growing, and I think what I would like to see your committee do, and what you're doing really well, is supporting these new options.

Thank you.

Chairman HEINZ. Thank you, Ms. Shea-Roger. Your complete statement will be included in the record at this point.

[The prepared statement of Ms. Shea-Roger follows:]

PREPARED STATEMENT OF PAMELA SHEA-ROGER

Mr. Chairman and Members of the committee, thank you for inviting me to speak to you today about shelter options for the elderly. My name is Pamela Shea-Roger, partner in OKM Associates and president of Housing Services Group. For the past 13 years, my work at both of these companies has been to develop and manage cost-effective programs that enable the elderly to live as independently as possible for as long as possible. In addition to direct service delivery, I am participating in several

national research projects which focus on the range of living arrangements available to the elderly.

I appear before you today to address some of the findings from my experience and my research regarding elderly shelter. In particular, I wish to provide you with an overview of different types of innovative elderly shelter programs around the country that are providing a high quality of life for some elderly in a cost-effective manner. Our elderly population is growing rapidly, and we need to support the development and expansion of these new types of specialized housing which address both physical and social needs.

Before I describe some of these options, allow me to dispel some myths about the elderly. The elderly do not fit into a single profile, nor can they be stereotyped more readily than any other age group. Someday both you and I will be among the elderly population, but we will be no more similar in needs or abilities than we are today. The elderly can be rich or poor; they can be independent, semi-independent, or dependent; they can be marathon runners or bedridden.

Because the elderly can be so different, there is no single answer to their shelter needs. Successful housing programs do not deal just with the physical housing. They deal with a combination of the physical environment, the services provided, and the resident's social and personal needs. We refer to this combination as "shelter" rather than housing.

The second myth about the elderly is that as people age they always lose control over their own lives. This need not be true. People may need more help, but they do not have to sacrifice control over their lives to get that help. Control is directly related to quality of life. In this morning's testimony, Secretary Anthony described the congregate housing program in Massachusetts. One of the most successful aspects of the program is that it allows the residents to make their own decisions about how they live and what services they use.

In the course of our research, we have identified many shelter alternatives in addition to congregate housing which serve the needs of certain elderly. These alternatives include:

HOME REPAIR

Elder homeowners need reliable and affordable home repair services if they are to remain in their homes. Local home repair programs often grant priority to elderly homeowners. They may provide inspectional services, referrals to certified home repair services, direct emergency repairs, and loans or grants. Programs for low-income elderly must include financial assistance, while higher income elderly can benefit from referrals of certified repair services.

PROPERTY TAX REDUCTION

To reduce elderly housing costs, elderly may be granted abatements, refunds, or exemptions by local governments from real property taxes. While elderly homeowners are the obvious beneficiaries, some jurisdictions will grant tax abatements to landlords of low income elderly tenants.

HOME EQUITY CONVERSION

Older homeowners borrow money against the value of their homes for living expenses, enabling them to remain in their homes for a period longer than their fixed incomes alone would allow. Equity conversion is most appropriate for homeowners whose homes are nearly mortgage-free, who are capable of continuing to live independently in their own homes, but who have fixed incomes which are insufficient to meet necessary home repair costs and other living expenses.

REVERSE ANNUITY MORTGAGES

Funds are lent to an elderly homeowner secured by a mortgage. The funds are paid in monthly installments to supplement regular income, and repayment is due in a lump sum at the end of the loan period. RAM's may be appropriate for elderly homeowners who wish to remain in their homes for a limited number of years, and are willing to use up some of their home equity in order to be able to do so.

SALE/LEASEBACK

An elderly homeowner sells the home to a buyer who grants the elderly seller a lease to occupy the home for life, or for a fixed period of time. The price is typically a net price (market value minus an allowance for rent) which reflects continued oc-

cupancy by the elderly person or household, and payment is made to the elderly seller typically in monthly payments. It is appropriate for an elderly person who wishes to continue to live independently in his or her own home, but does not want continued responsibility for maintenance.

SHARED LIVING

Two or more unrelated individuals share a single living unit, or share some common facilities within a building. While each member has his or her private space(s) such as a bedroom, living rooms, kitchens, and other facilities are shared. Shared living is most appropriate for single or widowed elderly, for whom space needs are minimal and companionship needs are great.

HOME MATCHING AND HOME SHARING

An older homeowner is linked with (either elderly or nonelderly) individuals who want to rent a room or share a home with someone else. If a program agency is involved, it screens the renter for compatibility and monitors a trial period of shared living. Again, the result is added income and increased capability to remain in one's current home.

ACCESSORY APARTMENTS

An extra, self-contained dwelling unit is constructed within an existing residence, providing a separate living space for an elderly person. It is most common among families who install a unit in their single family home to house a parent.

MANUFACTURED HOUSING

Factory-constructed housing may be used to provide an inexpensive, temporary extra dwelling unit to elderly relatives on a family-owned lot. The manufactured house is separate from the main house, yet next-door living can create a family compound atmosphere which may be appropriate for many eldrly with nearby relatives.

LODGING HOUSES, BOARDING HOMES, ROOMING HOUSES, AND SRO HOUSING

These are shelters which offer private rooms often with some shared facilities and living spaces. Boarding homes include meals, while the other shelter types may or may not provide access to shared kitchen facilities. SRO facilities tend to be old urban hotels. They all may serve a very silent, often invisible population of single, independent elderly.

DOMICILIARY CARE

A protected living arrangement which includes room and board plus personal care services. It is appropriate for adults who cannot live independently because of physical, visual, or mental impairments associated with age, yet who do not require 24 hour institutional care or nursing care.

LIFE CARE, CONTINUING CARE COMMUNITIES

These communities provide living accommodations, meals, and nursing and other health-related services to resident older persons for the life of each resident. The services are purchased by each person via a contract, typically secured with an up-front payment and a monthly fee.

CHANNELING SERVICES

Elderly assistance comes from many different sources. Some agencies attempt to coordinate the services for each of its elderly clients, possibly including homemaking, visiting nurses, homecare, chore services, meals, and social services.

ADULT DAY CARE

Care and assistance are provided at facilities for nonresident frail elderly. Daytime programs and services help to meet physical, social, and emotional needs so that the elderly may remain at home or maximize their independence.

ADULT FOSTER CARE

A foster family provides room, board, and personal care services to an older person who is no longer capable of living alone.

What can we do to encourage the continued expansion and growth of these elderly shelter alternatives?

We can make sure that a wide range of alternatives are available. Since the elderly do not fit any single profile of housing needs, we cannot rely on just a few shelter models. Instead, we need a continuum of alternatives which blend physical shelter and services appropriate to individual needs. Diversity, therefore, is the first critical ingredient for a successful elderly shelter policy.

Information is the second critical ingredient. The providers, their elderly clients, and their families and friends have to know about the programs in order to take advantage of them. Through our research, we are aware that this piece is missing: there is little sharing of information between people who are planning programs, people who are running programs, and people who need the programs. The people who run the most innovative programs have little time to document what they are doing and to disseminate information about their program. We need to develop methods of collecting information about programs and sharing the information at the local, State, and Federal levels.

Coordination is the third critical ingredient. The programs and services outlined above fall under the control of different federal, state, and local agencies. The regulations, funding mechanisms, and mandates of these agencies must be coordinated if the elderly are to take full advantage of the programs. While coordination among agencies at all these levels may seem like a giant task, the Massachusetts congregate housing program demonstrates that it can be done successfully and cost-effectively.

Thank you.

Chairman HEINZ. As previously advertised by Ms. Shea-Roger, James Firman is going to tell us about home equity conversions.

STATEMENT OF JAMES P. FIRMAN, ED.D., SENIOR PROGRAM OFFICER, ROBERT WOOD JOHNSON FOUNDATION, PRINCETON, NJ

Dr. FIRMAN. Thank you, Senator Heinz. I am pleased to be here. I would like to emphasize although I am an employee of the Robert Wood Johnson Foundation, any opinions I express are my own and not necessarily those of the institution for which I work.

I have been asked to talk with you about recent developments in the area of home equity conversion and their implications for helping chronically ill older homeowners to get the care they want and need at home. In my allotted 5 minutes I would like to briefly review some recent national and international developments which I think have some bearing on this issue and conclude with a few specific recommendations for congressional action.

As you know, and as the previous speaker referred, home equity conversion or reverse equity plans are designed to help house rich and cash poor homeowners unlock the value of their homes and convert it into income without being forced to move or to repay the loan for monthly income.

Most older persons, more than 16 million, are homeowners, and 80 percent of these own their homes free and clear. An estimated 2¼ million of these elderly homeowners are also in need of at least some help to avoid institutionalization.

In the past few years, there has been considerable speculation and debate about whether or not home equity conversion has any significant potential for helping older persons in need of long-term care to remain at home.

Recent analyses by Bill Weissert and Bruce Jacobs make it clear that home equity conversion has the potential to be a major source

of financing for both home care and long-term care insurance. For example, Weissert and Jacobs find that more than half, 56 percent of all high risk single elderly homeowners could generate $3,000 a year or more out of their home assets to pay for home health care or long-term care insurance.

Preliminary findings by Weissert and Jacobs also suggest that as many as 80 percent of all older homeowners could afford longterm care insurance to pay for nursing home stays if home equity conversion options were more readily available to them.

These findings by Weissert and Jacobs are consistent with my own earlier analysis that suggests that the net home equity holdings of older individuals currently in need of long-term care is probably $70 billion or more, and that accessible home equity conversion options could significantly enhance the ability of older homeowners to get the help they desperately want and need.

Another important line of research and development has been pursued by Prof. Jack Guttentag at the Wharton School at the University of Pennsylvania. He has been modeling a variety of alternative plans for converting home equity into cash to pay for medical expenses. He has developed options for both publicly and privately financed plans which can provide a degree of flexibility to consumers not now available in offerings currently on the market.

Guttentag has also modeled a plan for converting home equity into long-term care insurance premiums, which may have particular appeal to policymakers, practitioners, providers, and older people.

There is a particuarly good fit between long term care insurance and home equity conversion that has not yet been generally recognized. In fact, my study of these recent developments has led me to conclude that unlocking home equity may be the key to the development of accessible and affordable long term-care insurance programs.

When I last testified before this committee in July of 1982, I proposed consideration of an independent living loan fund, a program designed expressly to offer a line of credit to older home owners who had risk of institutionalization.

Since then, I have learned that the Japanese have implemented a similar program in the city of Musashino, near Tokyo. The purpose of the Musashino program is to assist house rich, cash poor elderly home owners who do not wish to be institutionalized to purchase health and social services not covered by Japan's national health insurance plan. At the present time, the program is administered by a private organization that is controlled by city government. Members get a basic package of monitoring and maintenance services and access to other services as needed. An interim report conducted by researchers at the Kuakini Medical Center in Hawaii showed that the program is doing quite well.

The Japanese have never been reluctant to learn what they can from Americans, and in this case, I think we should learn what we can from the Japanese.

These three recent developments make it clear to me that home equity conversion has significant potential for financing health and long term care needs of older persons. Whether or not this potential is realized is, of course, another story.

Although I firmly believe that major responsibility for innovation and delivery of financial services should remain in the private sector, congressional actions are needed to enable the private sector to deliver financial services that older homeowners need. I know that this committee and others in Congress have been considering home equity conversion issues for quite a long time. But so far there has been mostly talk and little action. The Alternative Mortgage Instruments Parity Act of 1982 introduced by you, Senator Heinz, is the only piece of constructive legislation that has so far been enacted by Congress.

Within the last year Congress has had two major opportunities to help make home equity conversion options more accessible and affordable, and in my opinion has blown both of them.

First, the FHA reversed mortgage insurance demonstration legislation introduced and supported by the Senate was killed in conference committee. This legislation should be reintroduced at the most opportune moment. The demonstration efforts outlined in this bill are critical to development of the reverse mortgage field in this country.

A second and potentially more serious problem is the so called Home Equity Conversion Act of 1984, S. 1914, introduced by Senator Specter, which is part of the Senate tax bill going to conference next week.

By requiring 40 years straight line depreciation on residential sale leasebacks, the Specter bill will make it much less attractive to invest in residential sale leasebacks than it is today. Unless the 40 year requirement is changed to conform with normal depreciation schedules, this bill will have disastrous consequences.

As written, the Specter bill will make residential sale leasebacks a safe harbor at which nobody will want to dock, and if they do, the boat will sink.

Although I have been a vocal advocate for legislative reforms to make home equity conversions more accessible and affordable, no legislation is preferable to bad legislation.

On the other hand, if this one inequitable provision were to be changed in conference, to enable residential sale leasebacks to be depreciated like other real estate investment, the Home Equity Conversion Act of 1984 would be a good bill and one that I would support.

Third, I urge this committee, the U.S. Administration on Aging, and the Health Care Financing Administration all to look more closely at the possibility of controlled demonstration of the independent living, loan fund concept. I think the recent analyses by Weissert and Jacobs and the demonstration experiences of the Japanese make a compelling case for demonstrations of reverse mortgage programs designed specifically to help chronically ill older home owners maintain independent living at home.

Senator Heinz, thank you for hearing me out. I commend you for your continuing interest and activism on this important issue. Home equity conversion is not the answer for everybody, but it does have great potential for helping a million or more older homeowners to maintain independent living.

The public and private sectors must continue to work together and not be afraid to act to bring about the programs which can enable older homeowners to help themselves.

Thank you.

Chairman HEINZ. Dr. Firman, thank you.

[Subsequent to the hearing, Dr. Firman submitted the following for the record:]

ADDENDUM TO THE STATEMENT OF JAMES FIRMAN

In my testimony on April 23, 1984, I described the so-called Home Equity Conversion Act of 1984 as an attempt to create a "safe harbor" that was being undermined by the language in subsection (a)(i)(1) specifying that the depreciation deduction for residential sale-leasebacks be "computed under the straightline method using a useful life of 40 years." The only one apparent purpose of this provision is to make residential sale leasebacks an unattractive investment. I believe this provision discriminates against older people and I urge that it be deleted.

Since the time of my testimony, I've learned that the intent of the bill has also been subverted by subsection (a)(i)(2)(A)(ii)(II) which states that the purchaser/lessor cannot be a "related party or tax shelter." If passed, this section would mean that the only groups of people likely to invest in residential sale-leasebacks would be prohibited from doing so by law. The effect of this section is to render the bill to the status of phantom legislation.

The Home Equity Conversion Act of 1984 started out as a laudable and responsible attempt to help make home equity conversion options safer for and more accessible to older home owners. The bill contains many good features, but if the two aforementioned sections are not deleted or changed, this bill can only honestly be called "the Anti-Home Equity Conversion Act of 1984."

Chairman HEINZ. And thank you for your very intriguing testimony on the kinds of things that can be accomplished with the equity that people build up. As you point out, it doesn't apply to everybody. But it can be a very substantial source of services and independence for a significant number of people who might have no other alternatives. I'll have some questions for both you and Ms. Shea-Roger in a minute, but I would like to ask Mr. Chellis to proceed with his testimony, which, as I understand it, includes some ideas on life care.

STATEMENT OF ROBERT D. CHELLIS, PRESIDENT, NATIONAL LIFECARE CORP., CHESTNUT HILL, MA

Mr. CHELLIS. Thank you, Mr. Chairman. In the few minutes I have I would like to focus on the development of congregate housing and life care. I think these two forms of elderly housing hold the most promise for meeting the needs of more and more middle income elderly for housing and for health care.

We've talked a lot about congregate today. Just one note about what we mean when we say life care. It's generally assumed to mean a housing situation for people over 65 that includes a prepayment and a monthly payment. And usually a substantial, and more often refundable payment at the front end. This could be from $30,000 to $130,000, typically $60,000 to $80,000, plus a monthly maintenance charge.

Somebody moving into a life care community gets an independent townhouse, cottage, or apartment, usually an apartment.

There is often a personal care area when you get more frail, and there is almost always either nursing on site or contracted for off site.

And what you're getting for your entrance fee up front is guaranteed life use of your apartment, and guaranteed access to appropriate social services and nursing care, and the guarantees vary.

The tendency is to make them less comprehensive and keep the sponsor out of the insurance business. But the resident knows that once they're on that site that they are in an appropriate setting for the rest of their life, that they will never be asked to leave for lack of funds, and that is a very secure and a very useful situation.

It seems to keep people physically and mentally active longer than the average retirement situation.

Congregate housing is simpler and more flexible, and it's a lot cheaper to set up than life care. You can turn an old school or even a factory or even a large single family house sometimes into a satisfactory congregate situation, and with a limited number of services to that site, you can help to bridge the gap between independent living and expensive nursing care.

With life care, you actually eliminate the gap between independent living and nursing care because the life care center encompasses its own health care setup.

Even more effectively than congregate housing, life care can keep residents in their apartment and out of nursing care longer. They age in place, if you will, in the best possible way.

The major problem today is how to meet the needs and desires of moderate income elderly with their enhanced expectations for housing and health care. Traditionally, congregate housing has been aimed at lower income elderly and life care has been aimed at upper income elderly, just because of the economics of it.

Life care has been almost always private financed. It is very rarely subsidized, except in the sense that some residents help to subsidize other residents. The challenge will be to increase the attractiveness of congregate housing and to decrease its cost, and to make the cost of life care more affordable, and try to appeal to the great numbers of the middle level income elderly, who are becoming more conscious of what they should be getting and are more demanding.

To encourage more congregate housing, it may be enough to enlarge the use of FHA insured mortgages and to allow tax-exempt bonds for market rate congregate projects, and then let the private sector respond to that.

The new HUD 221(d)(4) program has pretty good potential, but as I point out in my written testimony the requirement of a 1-year debt service set aside for that program is enough to make most private developers look elsewhere, because it will require up to 20 to 25 percent equity and it just is not an attractive investment.

But with minor changes in those equity requirements, it could be the elderly congregate housing program that people have been asking for for years. The program would serve 20 percent lower income and 80 percent market rate, so you would have a skewing of rents situation.

It will also expand the usefulness of congregate housing if the maximum use is made of available home care services, as other witnesses have testified, and this will enhance the continuum of care aspects of congregate.

If bedside care can be provided through home health type services rather than in an on-site nursing facility, and if those services can be properly licensed, they could quite economically bridge the gap between congregate housing and life care.

You would really have an overlapping of the two types of service. You would meet the needs for nursing care, while holding down nursing costs.

Life care, the development of life care, is held back and costs are kept high by problems with statewide certificate-of-need programs, and local zoning problems. The scope of the life care industry, by the way, is that it serves about 100,000 people; 100,000 out of 25 million elderly is not a great deal. There are possibly 300 true life care facilities in the country today; more than half of them were built in the last 14 years.

So it's a movement that is picking up speed, but still is serving only a real minority of the elderly who might enjoy that kind of program.

Just as an example of how difficult it can be to set up a life care project, when my firm tries to initiate a life care project, we first have to either search out or create a complex combination of circumstances. First we have to find a piece of land in an attractive area. It has to be affordable; it has to be near a population center. It should have available utilities, and there has to be zoning there which will allow a mixed use of as many as 150 to 400 apartments.

As Ms. Feingold has just said, there's a critical mass in some of these things, and if you get up to several hundred units you can much more easily afford the social services you need. And the zoning must allow you to include possibly low rise and medium rise housing units, plus a health care facility, small shops, and a fair amount of parking.

When you're trying to go into an attractive residential area, you're asking for things that a lot of attractive residential areas don't want to see in their backyard.

We often also negotiate with a local nonprofit sponsor who is willing to undertake the agonies of a long and risky development. Parenthetically, 95 percent of the life care complexes in the country are run by nonprofit, or sponsored by nonprofit institutions; 36 percent are run by for-profit management companies. But almost always they need a private developer to help them get the thing rolling.

You also need, when you're trying to find a life care site, a health planning situation where you can get a certificate of need for your on-site nursing program, and that can rule out whole regions in Massachusetts and whole States elsewhere in the country.

So you can see that we have major problems in finding the right location. Our prelimary work and the risk of failure are considerable. Like oil drillers spending fortunes on dry wells, in one 12-month period, as just 1 company, in a State with only 1 major life care center, we spent time and money on 24 false starts for life care projects. All of which looked doable in the beginning and not so doable as you get further into it.

To the degree that certificate-of-need procedures and zoning can be simplified, and development procedures made more routine and

predictable, costs can be brought lower, and more affordable to more middle income elderly people.

For instance, in Florida, they will grant what they call sheltered beds to almost any life care applicant; sheltered beds, after a three-year startup period, are to be used only by residents of the life care village, and not by the community at large.

So if the sponsor is willing to take responsibility for maintenance of those beds, they are allowed to have them, and the life care industry is booming in Florida. One sponsor has three villages within 1 mile of each other in Del Ray Beach, for instance.

In Massachusetts, as far as zoning goes, we have the antisnob zoning, which is a way of putting lower income projects into a number of neighborhoods which have no low-income housing. This kind of affirmative action policy if extended to elderly housing would be a tremendous help in expanding congregate and life care projects.

At present, problems with either zoning or certificate of need have stifled unknown numbers of projects so that anything which simplifies these approvals will decrease the risk and lower the costs, increasing the number of projects built and the number of options available for older people.

It seems to me life care communities resemble HMO's in many ways, in that elderly people are using their own funds, by unlocking the equity in their homes, as we've already discussed today, to build and maintain their own facilities and services, with some prepayment of health care.

It's their funds that build these life care villages; it's their funds that maintain them. They're like a self-insuring group of several hundred people caring for each other, totally within the private sector, and almost no burden on the State or Federal Government.

If the Government could encourage the private sector to develop life care facilities with proper safeguards, as they have encouraged HMO's, I think we would have the same potential for enhancing services while holding down costs overall, by just shifting incentives within the private sector.

Cooperative housing is another element which, with minor changes in the Internal Revenue Code, might be made flexible enough to self-finance so that elderly people can group together and share services.

Obviously, like care pooling, the more elderly people are willing to share common areas and services of their housing, the more economical that housing can be. By sharing they can also achieve economically a more gracious and health maintaining lifestyle than most of them have ever known before. How many places can you go where you are served your main meal in an attractive dining room, with housekeeping service, linen service, a staff of people to help when you make a request. It can be quite a revivifying experience for older people who have worked hard all their life, who do buy into one of these life care villages.

In unity, there is strength. Offered the right product, numbers of elderly have shown that they will pull together their resources to support shared housing in its various guises. And as private developers eager to serve this market, we ask, if you can't give us a laissez-faire system, give us a system with broad-based regulations

where there is flexibility and encouragement for the private sector, and we will be eager to develop housing in an innovative and useful way to serve this rapidly growing elderly population which will very soon include all of us.

Chairman HEINZ. Mr. Chellis. Thank you. I think you've got at least a few years ahead of you before you are ready for life care.

Your statement will be included in the record in its entirety.

[The prepared statement of Mr. Chellis follows:]

PREPARED STATEMENT OF ROBERT D. CHELLIS

INTRODUCTION

My associates and I appreciate the chance to voice optimism, vent frustrations, and make public some of the grand and constructive ideas that daily ricochet unappreciated around our offices and those of our colleagues in the elderly housing development field.

Few areas are more dynamic or exciting than elderly housing. There are risks in any development field, but this one has some psychic as well as financial rewards. And few fields are more gratifying to work in than one which provides housing. When well conceived, well made, and well managed, it can provide an immediately better environment for those who need it and live in it.

Like an increasing number of companies, my group of five local firms combines entrepreneurial development efforts with construction capability, and a housing management company. We are in the elderly housing business for the long haul, and hope that we improve on the quality of our product and services with each successive development effort.

What is important is for government agencies to find ways to encourage more housing by using the most economical mixture of incentives and simplified procedures.

The subject I'm asked to address is seemingly insoluble—how to build a quality product for those who can't afford to pay full price. For instance, we accept, in general, the concept of skewing, where the majority of rents may be raised to subsidize a minority who pay less, but within market forces this can only be done to a limited extent before the combination of higher-than-market rents and lower-income neighbors make the more affluent look elsewhere. Government vouchers such as section 8 certificates were a workable solution, but will become less of a factor as the program phases out. In any case, as a colleague has pointed out, today's housing production will, sooner or later, become lower income housing. For those who take the long view and are willing to wait, the trickle-down theory may work, as long as some production continues each year.

THE SHARP PROGRAM

"State housing assistance for rental production" (SHARP), an innovative new program here in Massachusetts, may be a more rapid way to encourage housing and a good successor to previous low to moderate income housing programs. Although it is an interest subsidy program, it is not an overly expensive program because the developer must pay back the subsidy, under a preapproved plan, in 15 years. The program may be used for family or elderly units, and requires 25 percent of the units in a project to be set aside for low to moderate income residents.

The State housing finance agency, MHFA, sells tax exempt bonds, then after construction Fannie Mae buys out MHFA. Since State housing finance agencies generally do a high quality job, and have experience and capability in underwriting, it seems reasonable to ask FNMA to liberalize their underwriting criteria somewhat for this program to encourage more production. If limited to 80 percent of value the amount of mortgage financing creates a serious equity burden for the developer whose return on equity is restricted. Any increase over 80 percent, preferably to 90 percent, would allow more projects to qualify, increasing production with no extra cost and only marginal extra risk to FNMA.

HUD MINIMUM PROPERTY STANDARDS

More flexibility (or flexibility more easily achieved) for HUD's minimum property standards, would assist production of units in urban areas, rehabilitated buildings, and so on. For instance, in an urban rehab, HUD might accept smaller living units,

possibly demanding larger common areas, or higher quality amenities, to allow a project to fit its site.

HUD PROCESSING

In general, expedited processing by HUD of applications would be greatly appreciated. The elderly do not have as long to wait as the rest of us, and deveopment costs could be held down.

202

The 202 program, which was effective and well understood, is already badly missed as it fades away.

CONSTRUCTION

Suspension for elderly housing of the Davis-Bacon Act requirement for "prevailing" wage rates for construction workers would save an estimated 7 to 10 percent in costs, and remove an inflationary pressure, while employing the same number of workers, at locally competitive wages.

COOPERATIVE HOUSING

Jerry Glazer, active with cooperative housing for the Ebenezer Society in Minneapolis, has said that if you keep older people active they'll require less government subsidy. And co-op residents tend to stay active. Co-ops have great potential for fostering a sense of personal control and self-reliance, with all the psychological and even physical benefits that can bring. Co-op residents, more than those living independently or in condos, are believed to generate a stronger sense of community and group enthusiasm and common purpose. A co-op can also be a fine investment, and an investment by individuals and not the government.

Two provisions in the Internal Revenue Code would, if altered, increase the numbers of co-op projects available as an option to the elderly.

Many elderly, possibly two-thirds, have equity in a home which can be transferred to another type of housing, whether a co-op, condominium, life care entrance fee, or other vehicle. A technical modification of section 216 of the Internal Revenue Code should be made to allow variable cash stock purchases in so-called "deep equity" co-ops. This would be consistent with the original intent of Congress which was to tax co-ops as single family housing. But forcing all residents to put in comparable cash investments is restrictive and unnecessary.

Also desirable would be to modify section 103(b) of the Internal Revenue Code to allow for inclusion of co-ops for the elderly under the multifamily tax exempt revenue bond program. This would allow co-ops to compete more effectively with other forms of housing which do qualify for tax exempt financing.

HOUSING AND NURSING, COMBINED FUNDING

Whether billed as life care, continuing care, or as housing which happens to adjoin a nursing center, the advantages of creating a continuum of care for older people are well documented. It would be highly advantageous to allow both housing and health care elements of a project to be combined for financing, since going through two different review processes is time consuming, costly, expensive, and difficult to schedule.

There are many ways to allow this to happen—such things as allowing nursing facilities into the 221-d-4 retirement service center package, or including housing in 232 nursing facility funding provisions. Restrictions against combining two types of shelter under one financing method discourage the most innovative and desirable types of projects.

RETIREMENT SERVICE CENTERS—HUD 221-D-4 PROGRAM

The current 221-d-4 program with its congregate services provisions and 90 percent FHA insured loans, has been heralded as the answer to demands for a congregate housing-with-services program for the elderly. However, as it stands, the requirement of a 1-year debt-service set-aside, in addition to the normal equity requirement and other reserves, is considered the "kiss of death" for the program. It raises required equity to the 20 to 25 percent range and makes other ventures more attractive. HUD's concern about potentially slow fill-up of a facility whose monthly fes, because of a mandatory service package, will be higher than for straight rentals,

is understandable. Nevertheless, there are many ways to adjust the program to answer the same concern, namely:

(1) Fund a 1-year debt service reserve in the mortgage.

(2) Require a feasibility or marketing study to reassure HUD that an adequate market exists.

(3) Conduct limited premarketing, allowing a certain number of rent deposits to show evidence of demand.

(4) Allow 100 percent funding of the program, like the 221-d-3 program, and retain the 1-year debt service reserve.

(5) Allow a refundable entrance fee deposit which, combined with the premarketing typical of life care, would both reduce the size of the required financing and provide evidence of marketability.

Another problem which should be corrected with 221-d-4 is the contradictory attitude towared services. Services are explicitly encouraged, but income from those services are not allowed into the calculation determining the size of the supportable mortgage. This is despite the ability to mandate a package including meals and other services, and the demonstrated willingness of older people to pay more for such a package. This kind of housing fills a need, can be demonstrated to keep elderly people out of expensive nursing facilities, and must be encouraged. Any one of the minor adjustments recommended above should be enough to make it work.

LIFE CARE

Life care—or continuing care—represents a growing movement, not unlike the movement toward HMO's, but so far on a small scale, serving possibly no more than 100,000 people so far. Life care allows elderly to personally help finance appropriate housing, social and health care provisions for themselves. Their entrance fees build their own independent living units, shared amenities, and health care and support facilities. Monthly fees provide support services such as meals, housekeeping, laundry, utilities, and varying packages of health care services. Especially for health care, the higher the fees, and the more it looks like an insurance program. For the well, it offers a lifestyle that is perhaps more gracious and carefree than any they have known before. And, if illness or chronic disease begin to dominate their lives, life care offers a maximum of support and reassurance. Evidence suggests that residents of life care or continuing care communities extend their active years, and spend les time in nursing beds.

Life care entrance fees represent a conversion of home equity into a more helpful and appropriate housing and service package, but unlike reverse mortgages, the trend is toward refundable entrance fees, so that family equity is, at least in part, preserved.

Life care villages receive no government subsidies, and the residents in fact are like a self-insuring group, creating and paying for their own facilities and services. But expenses are high and a real problem is that these facilities are often only affordable by the elderly in the upper 20 to 30 percent of income levels. Two major and expensive hurdles to development of these facilities are zoning approvals and certificate of need approval. If these byzantine local and statewide procedures were simplified and made more predictable, development risks would be reduced, costs could be more resonable, and more retirement centers could be built.

After development a major operational hazard and cost lies in health care guarantees relating to long term nursing care, which life care or continuing care facilities make to one degree or another. These insurance-like guarantees are costly, hard to calculate, and therefore add risk and expense.

It would boost and broaden the base of the life care industry, at reasonable cost to the government, to:

—Encourage zoning similar to what Massachusetts refers to as "antisnob" zoning, expanded nationally and applied to elderly housing and health care centers. This affirmative action "proelderly" move would help elderly housing and health care projects locate near pockets of elderly citizens with more reasonable effort and expense.

—Mandate a "sheltered bed" concept similar to that in Florida, where a certificate of need is virtually automatic if the sponsor agrees to admit only patients from his own continuing care complex after a startup period of several years. The operational problem of bed under-utilization is far preferable to the risk of being denied a certificate of need after spending money and time on a year or so of unsuccessful applications.

—Enact some catastrophic coverage of nursing care. This third pro-life-care recommendation would have major financial implications, but would relieve a

major gap in medicare coverage, namely noncoverage of long-term custodial nursing care. Now, catastrophic coverage is only available when older persons first bankrupt themselves, becoming eligible for medicaid coverage. An extension of medicare coverage to this area—even with an extremely high deductible—would be a major step in assuring the dignity and peace of mind of older people, who worry about that catastrophe which only strikes a minority of us—a years-long uninsured, custodial illness. In addition to helping all elderly, this would also help lower the costs and broaden the base of life care communities.

INSPECTIONS

A great factor in reducing development costs, delays and uncertainty would be to combine as many inspections as possible under one agency. Now, having no central authority with ability to approve or disapprove, no consolidation or uniformity of standards, and unpredictable, different timing and inspection schedules, major problems are created. With a dozen or more inspection agencies, the potentials for delay, confusion, and counter-productive directions is enormous.

Thank you for this chance to present ideas for the encouragement of more and better types of elderly housing. I am not a fan of "big government" or massive subsidies, so I would rather encourage programs which include incentives like tax exempt bonds, tax advantages, and simplified procedures. They allow the government to leverage its resources by mobilizing the incredible potential strength of the private development sector.

Chairman HEINZ. Ms. Shea-Roger, you have given us quite a list of options that are, to varying extents, available in various communities. One of the things we tend to do when we have a hearing, particularly in a great urban area such as Boston, is to forget the problems of elderly people in rural areas. Are any of the options that you mentioned particularly well suited to rural elderly?

Ms. SHEA-ROGER. I don't think any is best suited, but all of these options are available in rural communities as well as cities, and there is nothing that doesn't work for the rural elderly on this list as well as for elderly in the cities. Especially all the issues around home equity conversion, and sale leaseback.

A lot of those people own their own homes, and all of these are methods for getting them money so that they can stay where they are as long as they want to.

Chairman HEINZ. Could you provide for the record a list of any obstacles that exist, either for the rural, or, for that matter, for the urban elderly in having more access to those kinds of shelter alternatives you mentioned.

Ms. SHEA-ROGER. Yes. I think there are two levels of obstacles that you want to talk about; one, I can provide through the study that we're doing for HUD and we'll make sure when that's finished that you'll get a copy.

Chairman HEINZ. I'm particularly interested in that.

Ms. SHEA-ROGER. For every particular housing option there are specific obstacles, such as zoning problems, and finding the right site. But we would be glad to give you that information, and the report when it's finished.

But I think there are three things that I touched on today that I would like to talk about again that relate to all of these things that I think are very important that are obstacles against running any good elderly shelter program, whether it's an alternative program or not.

First is diversity. You have to have a number of different programs so the people can choose the thing that's best for them. It seems simple, but you talk to HUD who says that's not my job and

HHS says it's not my job. You have to have that diversity available.

The second thing, and one of the reasons I really like your amendments that you've proposed is information. One of the things that we're finding from the HUD study which is fascinating, and it seems so simple I don't know why we didn't know it, is that the people who are doing the innovative programs, the grassroots people don't have time to sit down and document what they are doing.

So that it's real hard for them to share information, so I think the idea of through the AAA's having a way, maybe not of direct service provision, because I've seen some of the same problems other people mentioned, but really providing information to the elderly, to their families, to service agencies about what these programs are and how they work is really important.

And then I will say, finally, as an obstacle, the thing that every other person here has talked about, which is coordination. And I see that as the greatest obstacle to any of these programs, Federal agency to Federal agency not talking to each other; State agency to State agency. Local agency to local agency.

I don't have the answer. But I can tell you what we did in Massachusetts and I think it's really exciting and I think it proves that there is hope. When we started the congregate housing program 10 years ago, the Executive Office of Communities and Development who sat here today with the Department of Elder Affairs never talked to each other before. There was no relation. You would go to a housing authority and say would you like to do congregate housing, and they would say, yes, can you guarantee me 40 years of services to go along with my mortgage? And that's the level that we started at.

State agencies have worked together in that program. The local agencies have worked together, and they have begun to work with the Federal agencies so that not only have we developed a program in Massachusetts that works, that keeps people out of institutions, that gets people out who shouldn't have been there, but one very interesting thing—I know I'm talking too much—that nobody brought up today that's fascinating about that program is now that the housers are talking to the service people it just doesn't provide service for the congregate people, but it's spilling over to all elderly housing. The DEA people, the home care people now work with the housing managers, and that's affecting the people that are in all subsidized housing programs in the State, and not just the congregate program. And I think that's interesting, too.

So I would say coordination, coordination, coordination.

Chairman HEINZ. Yes. And I want to say that you're quite right about the fact that the Department of Elder Affairs has been working with these other service providers, and the housing providers in Massachusetts. I was very impressed to see what is taking place here.

Dr. Firman, you made a number of very helpful and penetrating observations about various methods of achieving home equity transitions. It's easy to imagine if home equity conversions, reverse annuity mortgages, or sale lease-backs become popular, that many fast buck operators may prey on the elderly. Somehow some kind

of scheme might develop to take advantage of and defraud the elderly for very minimal services or for very undependable payments in exchange for their signing away all of their equity. How can we protect the elderly, as consumers, the more we get into these various methods for converting equity?

Dr. FIRMAN. I think there are two parts of that answer. One, I think that independent counseling is essential to any sort of financial program such as this. And in fact in the good programs that are working in California, in part they are working because the older homeowners can get independent counseling and find out whether it's a good idea or it isn't a good idea.

In fact, in one of the most successful programs, four out of five people who walk through their door wind up being told, "No, home equity conversion is not the answer to your problems. You're eligible for SSI, go down and apply for that, or there's another solution for you."

One way to assure that independent counseling is available is to either publicly support or publicly mandate it in a home equity conversion program.

A second way is through the introduction of FHA demonstration legislation. For any program where there will be some reverse mortgage insurance you can require that those programs meet certain criteria and certain standards.

And so I share with you the concern that consumer protection is important, but I don't think that we should let that be the barrier that prevents the home equity conversion option from becoming available.

Chairman HEINZ. You mentioned a publicly chartered body in your testimony. Do you want to enlarge upon that?

Dr. FIRMAN. That was the Japanese approach. I have not had the opportunity to go over and visit it and find out more about it personally. But it seems to me that the approach of a publicly sponsored entity with perhaps publicly chosen members dominating the board is one viable approach te achieving that arm's length degree of consumer protection that's essential.

Chairman HEINZ. As you look at the universe of elderly that exists today, who might benefit from some form of home equity conversion, how many people are we practically talking about who would truly benefit from it? Is this a very small group? Or is it a substantial group? Is this an area that every finance company, bank, savings and loan, or financial institution ought to be interested in because it's a boom of the future, or is it just going to be a little trickle of people who really fit into this particular kind of square hole?

Dr. FIRMAN. I think it will be the wave of the future. I think that the policies of the U.S. Government have been to encourage people to invest in their homes. We've given them all sorts of tax breaks to buy homes and pay off the mortgages. We have put people in the situation that they're in now. I think that the $700 billion number is too big for somebody not to figure out a way to crack it.

In terms of who can it help, I think there are different numbers. It depends on what kinds of help they need. Of the people currently living outside of institutions who need home care, my estimate is about 1 million of them could benefit from these programs.

Of the larger population of older persons in need of long term care insurance, and we can argue that we all need long term care insurance, then we're talking about 80 percent who could potentially afford to purchase premiums, if programs were available.

So, for different needs, the number who could be helped ranges from one-third to 80 percent of the home owner population, keeping in mind that there is a significant portion of the population that are renters, and for whom this will never be an answer.

Chairman HEINZ. That's a fairly substantial proportion. Is my understanding correct that once you get much below $30,000 here in terms of the level of assets needed to make this work that you pretty much have gotten below the critical mass point?

Dr. FIRMAN. In general, yes, but I think there are exceptions. In the program in Buffalo, that has the purpose of helping older home owners keep up their homes, the average home has a value of about $15,000, and yet it does provide enough equity to provide for maintenance on the homes. It also depends on how old the people are.

One of the reasons that there is a particularly good fit between financing long term care and home equity conversion is that people in need of long term care tend to be over 75, tend to be single, tend to be living alone, all of which are positives from the perspective of the amount of equity that would be available to convert.

Chairman HEINZ. I can't resist saying I'm quite fascinated by that match. Given the state of our long term care policy direction in this country—which I would charitably call running around in circles—there is a great opportunity here if the insurance industry, for one, could develop a product that didn't sound like death insurance. They've made fortunes out of selling life insurance in spite of the fact that it's insurance that you collect only if you die. If they could figure out how to market "independence or dignity insurance," rather than "nursing home insurance" or "losing-your-ability-to-operate-independently-insurance," there might truly be a genuine market that they would do well to service. With appropriate public and private involvement we could conceivably see that kind of insurance being available for moderate and low income people in the same way as the medicaid program, for all its imperfections, makes certain kinds of health care available for people who can't afford it.

Mr. Chellis, you've described the opportunities for life care centers. Can we expect the private sector to develop either life care or congregate models for people of moderate and lower income?

Mr. CHELLIS. Absolutely. That's the market we would like to work on. The problem, as I say, is bringing down costs. You could do the modular housing that somebody mentioned today. You would have a less expensive health care system. I have a college intern——

Chairman HEINZ. Would you tell us how we could have a less expensive health care system—in 30 seconds? [Laughter.]

I'm just kidding.

Mr. CHELLIS. No, but I think through the delivery of home care, of services to the bedside in an apartment, if you can deliver a skilled nursing situation into the apartment that should be cheaper

than transferring somebody to a skilled nursing center which you have to build and maintain before you do that.

Chairman HEINZ. You're talking about delivering the appropriate level of care.

Mr. CHELLIS. Absolutely. The appropriate level. But doing it, as I think everybody today has been advocating, trying to do it without moving the resident, or moving them as seldom as possible, and delivering as much care into their own home as you can.

Chairman HEINZ. What about HUD's 221(d)(4) retirement service center model? Is that going to work? Can it work?

Mr. CHELLIS. We think it has a lot of potential, but it needs at least one major modification. I think in my prepared testimony I referred to about five possibilities for, we think, making that workable. And it includes eliminating the—well, the problems seems to be the need for a 1-year debt service set aside, which is such a large amount of money that it makes the total equity rather difficult to deal with. Some of the possible solutions would be having a premarket study, offering HUD a market study that says we've surveyed the market, we've looked at the demographics, and there clearly is a market for this kind of product.

Just to back up a little bit, I think HUD has required that 1-year debt service set-aside because they feel that because of the congregate services that the 221(d)(4) program will allow monthly rents are going to be much higher than they would be for straight apartments. And because those rents will be higher, it will be harder to rent and slower to rent and it may take you a year to rent. Therefore, HUD has said, "Give us a 1-year debt service set-aside and make sure you have the thing on a solid footing."

But that reserve is, we feel, too high. So we think if there were other ways around that, where you could either show a market study in advance, or have recourse to some other amount of funds, or premarket units. That's one of the life care village techniques, to premarket units, so before you ever break ground and secure your construction loan you've got some sort of firm commitment for maybe 50 percent of your units. And you can show viability to your banker.

That kind of thing, any one of half a dozen things would, or, I think, should satisfy HUD, make it a workable program, and still offer the safeguards they want.

Chairman HEINZ. I note that on page four of your testimony you have five suggestions and we will pay close attention to those, as, indeed, we will to the other very good suggestions we've received today.

Our time for this hearing has evaporated rather more quickly than I had expected. If there are any people in the audience who want to submit for our record testimony or statements, we will be glad to accept them and we will keep the hearing record open for an appropriate period of time to receive any such statements. Either give them to our staff or drop them in the mail to the Special Committee on Aging.

I particularly want to thank not just our witnesses. Those who come last probably deserve the greatest thanks for having the patience to wait their turn. But I really am indebted to the Mayor, Ray Flynn, for his courtesies, and to his staff, as well as to the Citi-

zens Housing and Planning Association, all of whom have been most helpful to us.

So may I thank everybody who has participated, everybody who has helped, and those who have just quietly observed without appearing to lift even a finger but have nonetheless assured that every single word of this hearing has been properly transcribed. We thank all staff and all participants, and the members of the public who were interested enough to attend.

Thank you all very much. This hearing is adjourned.

[Whereupon, at 4:39 p.m. the hearing was adjourned.]

APPENDIXES

Appendix 1

STATEMENT OF PATRICIA A. RILEY, AUGUSTA, MAINE, DIRECTOR, BUREAU OF MAINE'S ELDERLY, DEPARTMENT OF HUMAN SERVICES

I am delighted to see your interest in congregate housing and home equity conversion. Since the late 1970's, Maine has been developing both of these initiatives and I wish to share our experience with you. Since Mr. Rowland referred to some dated information regarding our program in his testimony, I thought I would provide more recent and accurate data.

Background

Maine law, enacted in 1980, defines congregate housing as "residential housing consisting of private apartments and central dining facilities and within which supportive services are provided to functionally impaired elderly occupants who are unable to live independently, yet do not require the constant supervision and/or intensive health care available at intermediate or skilled nursing facilities".

Since 1980, the State has provided funds for congregate housing services programs (CHSP) which support the costs of health and social services at congregate housing sites. Financing for Maine's congregate housing facilities has come from Federal Farmers Home and HUD housing programs.

Presently, eight congregate housing sites in Maine receive State CHSP funds. Housing at these sites has been financed by Farmers Home (515 program) and HUD (section 8 new construction/substandard rehabilitation and moderate rehabilitation programs).

On the State level, the unit on aging, the Bureau of Maine's Elderly, administers the State CHSP which includes: promulgating regulations governing CHSP's; administering program funds; and certifying, monitoring, evaluating, and providing technical assistance to local programs. The bureau works closely with State housing finance agencies to coordinate the approval, development, and operation of congregate housing projects.

On the local level, area agencies on aging, as the grantees of State CHSP funds, are responsible for oversight of the operation of local congregate services programs. Area agencies work closely with local housing sponsors and health and community services agencies to coordinate the operation of congregate housing programs. Area agencies on aging provide case management service to congregate housing tenants and subcontract with community agencies for the delivery of other supportive services (meals, personal care, housekeeping, etc.) needed by tenants.

Tenants of Congregate Housing

Recently established criteria for participation in CHSP's requires that participants: (1) Be functionally impaired in at least four ADL or IADL activities (as measured by an assessment instrument used to screen all applicants to long-term care); (2) be in need of at least two "core" services (meals, housekeeping, personal care, transportation) and case management; and (3) be without an adequate support system to provide for assistance needs. In addition, priority for congregate housing tenancy is given to those low-income elderly persons in greatest need of housing assistance. The criteria and selection priorities target congregate housing resources to elderly who are low income, functionally impaired, poorly housed and without sufficient support systems to provide for their assistance needs. This profile of Maine's congregate housing tenant mirrors the profile of those elderly at greatest risk of institutionalization. The program therefore offers tremendous potential for delaying

or preventing unnecessary institutionalization of the elderly. The fact that congregate housing is indeed a viable alternative for elderly who may be misplaced in nursing or boarding homes was demonstrated at the State's first three congregate housing developments, where 30 percent of tenants moved into congregate housing from nursing homes and boarding homes.

Types, Amounts, and Cost of Services Used by Congregate Housing Tenants

The following table summarizes the types, amounts, and costs of services used by congregate housing tenants at two demonstration sites for a recent 3-month period.

	Meals	Housekeeping	Personal care	Nursing [1]	Transportation
Percent of tenants using service	90	89	35	17	15
Average number of units used (monthly)	[2] 37	[3] 5	[3] 8	[3] 4	[4] 2
(Lowest) unit cost of services provided	$2.00	$4.69	$6.50	$41.50	$4.00
Average monthly cost of "core" services	$74.00	$23.45	$52.00	$166.00	$8.00
Average total monthly cost of services	$323.45				
Average cost of case management services	$50.00				
Average cost of administration of service programs	$16.00				
Average total monthly cost of services program per tenant	$385.45				

[1] Cost of all nursing services were reimbursed through medicaid and medicare.
[2] Meals. [3] Hours. [4] Trips.

It is interesting to note that almost half of the cost of all services reflects medicare or medicaid reimbursed nursing services. The medicare approved rate of $41.50 per visit to each client could probably be greatly reduced in a congregate setting if a lower hourly rate were established for a project, not client, visit. Excluding the high cost of nursing services, used by only a small percentage of tenants, the average monthly cost of services is $223.45.

Cost of Housing

The following reflects the monthly market rents at the State's eight congregate housing sites: Site 1, $330; site 2, $381; site 3, $422; site 4, $595; site 5, $624; site 6, $645; site 7, $673; and site 8, $680.

Cost of Congregate Housing

While congregate services costs are generally predictable and similar statewide, congregate housing costs vary greatly depending on the type of housing program used. The highest housing cost, at $680 per month, was found at a section 8 new construction/substantial rehabilitation project financed in 1982. The lowest housing cost, at $330 a month, was found at a section 8 moderate rehabilitation project financed in 1983. Coupling these figures with service figures, excluding nursing services, the cost of congregate housing can range from $553 to $903 a month.

Cost of Congregate Housing Compared With Boarding and Nursing Home Costs

The following compares average monthly costs of nursing home, care cost reimbursed boarding home care and congregate housing in Maine: Nursing home, $1,362; boarding home, $645; and congregate housing, $767.

Summary

Maine has found congregate housing to be a very high quality housing option for the frail elderly. The option can, depending on the housing resources used to create the congregate housing facility and cost controls used to provide home health nursing, be a very cost effective alternative to nursing home programs. It is somewhat comparable in cost to boarding homes although the quality of congregate housing shelter is far superior to most boarding homes which offer the elderly multiple occupancy bedrooms. Through the cooperative efforts of housing sponsors and agency on

aging sponsors, the program has been administered in an efficient and effective manner on both the state and local levels.

Finally, through a Federal DHHS grant for home equity conversion, Maine was able to purchase a large older home from a disabled elderly couple, convert it to apartments with common dining space, guarantee the former owners lifetime residency and establish a new model of congregate housing which utilizes home equity conversion concepts. Our most recent activities have been focused on similar rehabilitation of large old homes rather than expensive new construction.

Recommendations for Federal Action

1. PROVIDE ADDITIONAL FEDERAL HOUSING RESOURCES FOR CONGREGATE HOUSING FACILITIES

While the State of Massachusetts has been able to finance new congregate housing facilities, the vast majority of other States, like Maine, simply do not have the resources to finance new housing.

Converting some of the existing stock of elderly housing to congregate housing can offer a partial answer. However much of the stock cannot be converted either because the housing is not well located or architecturally suitable for congregate housing or because sponsors of existing housing do not want to participate in CHSP's. In Maine, we have witnessed these two barriers.

Therefore, new resources are needed to create congregate housing facilities. At present, the only Federal housing program which might be used for congregate housing for the low-income elderly is the HUD 202 program, a program with very limited funding when compared with HUD section 8 and Farmers Home Administration 515 (with rental assistance) program funding levels of the late 1970's. While Maine is trying to use the 202 program to create additional congregate housing, the State can expect to receive only 80 units of 202 housing a year. If one-half of all these units were developed as congregate, it would still take Maine over 75 years to achieve its congregate housing unit goals. Clearly, additional Federal housing resources are needed if congregate housing production is to begin to keep pace with the tremendous need for this housing option.

2. PROVIDE FEDERAL SERVICE RESOURCES FOR CONGREGATE HOUSING PROGRAMS

While Maine, Massachusetts, and a handful of other States have been able to fund CHSP's, again the vast majority of States do not have the resources to support this initiative. Therefore, we concur with Secretary Rowland's suggestion that CHSP funding be included in the medicare and medicaid programs.

3. REEVALUATE THE FEDERAL APPROACH TO PROVIDING CONGREGATE HOUSING WHICH WAS ESTABLISHED IN THE CONGREGATE HOUSING SERVICES ACT OF 1978

While this act created some excellent congregate housing programs, we see major limitation in HUD's congregate housing program.

First, the program limits sponsorship of congregate housing to public housing authorities and 202 housing sponsors. Most Maine communities have no public housing authorities or 202 housing and would therefore be excluded from the HUD program, although a community need for congregate housing might exist. The program also excludes FmHA financed housing and housing sponsored by private and profit developers and financed by an array of other HUD programs. Maine has had an excellent experience creating congregate housing with both profit and nonprofit sponsors using FmHA and several different HUD financing programs. A Federal approach to creating congregate housing should be as flexible.

Second, a Federal CHSP might not be best located within HUD. While the agency obviously has expertise in the field of housing, it lacks similar expertise in the area of human services administration. From our contact and experience with two HUD funded CHSP's in Maine, it appears that HUD provides very little technical assistance, monitoring or evaluation of local congregate housing programs.

Massachusetts and Maine, as well as several other States, offer models for the administration of CHSP's by State units on aging. The Federal Government should consider these as well as other alternatives to HUD administration of congregate services programs.

Thank you.

Appendix 2

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

Dear Chairman Heinz: If there had been time for everyone to speak at the hearing on "Sheltering America's Aged: Options for Housing and Services," in Boston, Mass., on April 23, 1984, I would have said:

[The following replies were received:]

B. PRZYBYLAKA, BOSTON, MA

I want to make three points:

The need to support elderly homeowners, especially those with multiunit buildings in our cities, as they often provide the last remaining source of private market housing affordable to other low and moderate income households, you and elderly alike—through provision of home repair services, property tax assistance, assistance with the demystification of the bureaucracies with which they must deal, fuel assistance; in-home care.

The need to pass enabling legislation and departmental rulings and regulations to allow for the development of home equity conversion mechanisms—specifically, developing an FHA mortgage insurance program for reverse mortgages; encouraging FNMA and FDMC to develop secondary markets for these mechanisms; urging the IRS to rule on the applicability of capital gains exclusion and depreciation in sale-leaseback transactions.

As the population ages, and lives to an older age, we are going to have to come to terms with the tremendous demand on our health care system which will (and is) resulting. Health care has to be brought back to where people live, much more emphasis has to be placed on preventive care. Congressional committees on aging must take a hard look at what medicare and medicaid now function, and at the type of health care that is truly needed by elders; not at the type of health care they presently receive as a result of medicare/medicaid guidelines.

CAROL JEAN SUITOR, NEWTON, MA

I applaud your efforts in behalf of our Nation's elderly. It is clear that a diversity of approaches, flexibility, and coordination of efforts will all be important to making substantial progress.

A very informative hearing. We're glad you came to Boston.

SUSAN SWANDER, BOSTON, MA

I would highlight this administration's lack of support for housing for older Americans—i.e., 14,000 202 units—280 units per State with a 75-unit capacity equaling 4 developments per State—a very low commitment to a rapidly growing population.

I would echo Ellen Feingold's plea for support of social service coordination as an integral part of housing for older people.

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